D BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05			
CARE MEDICAID TRICARE CHAMF	PVA GROUP FECA OTHE	R 1a. INSURED'S I.D. NUMBER (F	PICA For Program in Item 1)
care #) (Medicaid #) CHAMPUS (Sponsor's SSN) (Membe	r ID#) HEALTH PLAN BLK LUNG (SSN) (ID)		
IT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	INSURED'S NAME (Last Name, First Name, Midd	dle Initial)
NT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
STAT	Self Spouse Child Other E 8. PATIENT STATUS	CITY	STATE
TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (In	clude Area Code)
()	Employed Student Part-Time Student	()	
I INSUREDY NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBI	ER
NSURED'S IDLICT Y GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
according to the Alask	top portion of the CMS a Medicaid Claim form	Instructions available	
online at http://www.r	medicaidalaska.com/	oroviders/Billing1.shtr	<u>nl</u>
ANCE PLAN NAME OF PROGRAM NAM	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to an	d complete item 9 a-d.
READ BACK OF FORM BEFORE ONLY STATE OF AUTHORIZED PERSON'S SIGNATURE Interest this claim. Lake request person of government to	G & SIGNING THIS FORM. The release of any medical or other information necessary If or to the party who accepts accompany	INSURED'S OR AUTHORIZED PERSON'S SIG payment of medical benefits to the undersigned	
cess this claim. I also request payment of government be with	of or to the party who accepts assignment	services described below.	
DF CURRENT: ILLNESS (First symptom) OR 1:	DATE 5. IF PATIENT HA HAD S ME OR SIMILAR ILLNES GIVE FIRST D. F. MN DD YY	SIGNED SIGNED UNABLE TO WORK IN CURE	RENT OCCUPATION
PREGNANCY(LMP)		FROM TO	
	7a.	18. HOSPITALIZATION DATES RELATED TO CUR MM DD YY MI FROM TO	M DD YY
IVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHAR	IGES
OSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,	2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. I	NO.
	3.	23. PRIOR AUTHORIZATION NUMBER	
DATE(S) OF SERVICE B. C. D. PROC	4. CEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I.	J.
	plain Unusual Circumstances) DIAGNO	S DAYS EPSOT ID. Family UNITS Plan QUAL.	RENDERING PROVIDER ID. #
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		28. TOTAL CHARGE 29. AMOUNT PAID	D. BALANCE S JE
RAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	B ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		5
	YES NO	\$ \$ \$	
	(For govt. claims, see back)	\$ 33. BILLING PROVIDER INFO & PH # (
TURE OF PHYSICIAN OR SUPPLIER 32. SERVICE I NING DEGREES OR CREDENTIALS that the statements on the reverse	YES NO		

VED BY NATIONAL UNIFORM CLAIM COMMITTEE		on in the months of	D. MUMPED	PICA [
DICARE MEDICAID TRICARE CHAMPUS (Medicaid #) (Sponsor's SSN)		CA OTHER 1a. INSURED'S I		(For Program in Item 1)
ENT'S NAME (Last Name, First Name, Middle Initial	3. PATIENT'S BIRTH DATE	SEX 4. INSURED'S N	AME (Last Name, First Name,	Middle Initial)
ENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO Self Spouse Child	INSURED 7. INSURED'S A	DDRESS (No., Street)	
	STATE 8. PATIENT STATUS	CITY		STATE
DE TELEPHONE (Include A	Single Married rea Code)	Other ZIP CODE	TELEPHON	E (Include Area Code)
()	Employed Student Student	Part-Time Student	()
ER INSUREDY NAME (Last Name, First Name, Mic	dle Initial) 10. IS PATIENT'S CONDITION R	RELATED TO: 11. INSURED'S I	POLICY GROUP OR FECA NU	JMBER
ER INSURED'S INLICA VI GROUP NUMBER	a. EMPLOYMENT? (Current or P	Previous) a. INSURED'S D. MM	ATE OF BIRTH DD YY	SEX F
ER INSURED'S DATE OF BIRTH	b. AUTO ACCIDENT?	PLACE (State) b. EMPLOYER'S	NAME OR SCHOOL NAME	
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FRANCE PLAN NAME OR PROGRAM NAM	YES 10d. RESERVED FOR LOCAL US	NO d. IS THERE AN	OTHER HEALTH BENEFIT PL	AN?
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ualifier, Place of Serv dministered, Diagnosi	s Pointer, \$ Che ges	NDC Unit of Me Units, and Rende	asure, NDC Pering Provide	Units or ID.
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ualifier, Place of Served dministered, Diagnosi served for local use	ce, Procedure Cole, Ns Pointer, \$ Charges 17b. NPI	NDC Unit of Me Units, and Rende	asure, NDC pring Provide pring Provide sc	Units or ID.
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MEDICARE MEDICAID TRICARE CHAMPVI Medicare #) (Medicaid #) (Sponsor's SSN) (Member III	- HEALTH PLAN - BLK LUNG -	1a. INSURED'S I.D. NUMBER (For Pri	ogram in Item 1)
TIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Ini	itial)
TIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
STATE	Self Spouse Child Other 8. PATIENT STATUS	CITY	STATE
ODJ TELEPHONE (Include Area Code)	Single Married Other	TID CODE	1-0-1-1
	Employed Full-Time Part-Time Student	ZIP CODE TELEPHONE (Include	Area Code)
HER INSUREDY NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
HER INSURED'S ADLIGN A GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	MM DD YY	SEX
HER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	F
PLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES NO		
BURANCE PLAN NAME OR PROGRAM NAM	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and com	nplete item 9 a-d.
READ BACK OF FORM BEFORE OMN STORM ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE IN (thorize to process this claim. I also request payment of government become siting	& SIGNING THIS FORM. release of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S SIGNATU payment of medical benefits to the undersigned physic 	
low.	If or to the party who accepts assignment	services described below.	
GNED ATE OF CURRENT: ILLNESS (First symptom) OR 15.	DATE IF PATIENT HA HAD'S WE OR SIMILAR ILLNESS. GIVE FIRST D. F. MN. DD YY.	16. DATES PATIENT UNABLE TO WORK IN CURRENT	OCCUPATION
M DD YY INJURY (Accident) OR PREGNANCY(LMP) AME OF REFERRING PROVIDER OR OTHER SOURCE 17.		FROM TO TO 18. HOSPITALIZATION DATES RELATED TO CURRENT MM DD YY	
17	Step 2 - Continued	FROM TO	DD YY
ESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
AGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2,	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.	
3.		23. PRIOR AUTHORIZATION NUMBER	
	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I.	J.
DD YY MM DD YY SERVICE EMG CPT/HCP			RENDERING PROVIDER ID. #
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EDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE 29. AMOUNT PAID \$). BALANCE LUE
CLUDING DEGREES OR CREDENTIALS	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (
certify that the statements on the reverse oply to this bill and are made a part thereof.)			
ED DATE a.	b.	a. b.	
Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM (

PPROVED BY NATIONAL UNIFORM CLAIM COMMITT	<u>5002</u> Ex	-	PICA T
MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA	OTHER 1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
hyphens or spaces within the newever, a leading zero is coding redist have a leading zero. Example : a product with a added before the "9" resulting submitter as 3,19123456780	e NDC number. The NDC nommonly missing from one or added. n NDC number of 01234-56 ng in a NDC number of 0123	wed by the NDC number. Do umber must be in the 11 digit of the 3 sections. Whichever 78-9 on the package would had 4-5678-09. This NDC number 7-89 on the package would have 18-90 on the package would have 19-90 on the pack	(5-4-2) format; section is missing a ave a leading zero er would be
added before the "1 resulting	ng in a NDC number of 0123	4-0567-89. This NDC numb	
submitted as N40123405678	0		
S. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		EFIT PLAN? return to and complete item 9 a-d.
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IMPORTAN'		de units may not be the same ctual dose of medication adm	
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		at the correct billing unit is for the Billing Unit Decision 7.	
		quic.aspx) prior to submitting	
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5. FEDERAL TAX I.D. NUMBER SSN EIN 1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I Certify that the slatements on the reverse	32. SERVICE FACILITY LOCATION INFORMATION a. b.	NO \$ \$ 33. BILLING PROVIDER INFO & PH #	MPI STATE OF THE S

1. MEDICARE MEDICAID TRICARE	CHAMBIA CROUD	PICA
1. MEDICARE MEDICAID TRICARE CHAMPUS (Sponsor's S	(SN) (Member ID#) HEALTH PLAN BLK LUNG (SSN) (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle	nitial) 3. PATIENT'S BIRTH DATE SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CIT	STATE 8. PATIENT STATUS	CITY STATE
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9. OTHER INSURED' NAME (Last Name, First Name	Employed Student Student Student In Italian (Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		The appearance state and accounting a square sign of the square state of the square st
a. OTHER INSURED'S IDLICA A GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY M F
b. OTHER INSURED'S DATE OF BIRTH	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAM	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BE		YES NO If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
 PATIENT'S OR AUTHORIZED PERSON'S SIGNA' to process this claim. I also request payment of gove below. 	TURE Inthorized e release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT: MM DD YY ILLNESS (First sympt INJURY (Accident) OF PREGNANCY (LMP)	om) OR 15. IF PATIENT HAY HAD S ME OR SIMILAR ILLNESS. GIVE FIRST DI E MN DD YY	. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO TO
17. NAME OF REFERRING PROVIDER OR OTHER S	OURCE 17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
19. RESERVED FOR LOCAL USE	170. (41)	20: OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJUR	Y (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
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From To PLACE OF	(Explain Unusual Circumstances) DIAGNO EMG CPT/HCPCS MODIFIER POINTE	F. G. H. I. J. DAYS EPSOT ID. RENDERING OR Family UNITS Pan QUAL. PROVIDER ID. #
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6		NDI
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? For gowl, claims, see back) YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 0. BALANCE JUE 8 5
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		
SIGNED DATE	a. NPI b.	a. b.
NUCC Instruction Manual available at: ww	DW DUCC Ord	APPROVED OMB-0938-0999 FORM CMS-1500 (08/05