MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V — ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): JOHN Jones
2. DATE OF BIRTH: 06031956
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE FEMALE
5A. PATIENT'S SEX: MALE X FEMALE
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: AB12345X
5B. PATIENT'S TELEPHONE NUMBER ( )
6B. PRIVATE INSURANCE NUMBER
GROUP NO.
RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT X; CRIME VICTIM X; AUTO ACCIDENT X; OTHER LIABILITY X
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION MM DD YY
15. FIRST CONSULTED FOR CONDITION MM DD YY
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES NO
16A. EMERGENCY RELATED YES X NO X
17. DATE PATIENT MAY RETURN TO WORK MM DD YY
18. DATES OF DISABILITY TOTAL PARTIAL FROM MM DD YY TO MM DD YY
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DOCTOR'S NAME
19A. ADDRESS (OR SIGNATURE SHF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER: DOCTOR NPI
19D. DX CODE
20. NATIONAL DRUG CODE
20A. UNIT
20B. QUANTITY
20C. COST
NDC info entered to the left of this field will only be associated with the 1st claim line below
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐
LAB CHARGES
22A. SERVICE PROVIDER NAME
22B. PROF CD
22C. IDENTIFICATION NUMBER
22D. STERILIZATION ABORTION CODE
22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE
1.
2.
3.
22F. POSSIBLE DISABILITY Y N X
22G. EPSDT C/THP Y N X
22H. FAMILY PLANNING Y N X
23A. PRIOR APPROVAL NUMBER
23B. PAYM'T SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
DATE 13	11	92340	RB				DX CODE	1	15.00		

24M. INPATIENT HOSPITAL VISITS — FROM MM DD YY — THROUGH MM DD YY — 24N. PROC CD — 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Sign HERE
SIGNATURE OF PHYSICIAN OR SUPPLIER
26. ACCEPT ASSIGNMENT YES X NO
27. TOTAL CHARGE: 15 00
28. AMOUNT PAID: 0 00
29. BALANCE DUE: 15 00
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
DR JAMES SMITH
312 MAIN STREET
MIDDLETOWN, N.Y. 11211
TELEPHONE NUMBER ( ) EXT.
25A. PROVIDER IDENTIFICATION NUMBER: EITHER NPI
25B. MEDICAID GROUP IDENTIFICATION NUMBER: OR→OFFICE NPI
25C. LOCATOR CODE: 003
25D. SA EXCP CODE
32A. MY FEE HAS BEEN PAID YES NO
DO NOT WRITE IN THIS SPACE.
COUNTY OF SUBMITTAL
25E. DATE SIGNED: DATE
32. PATIENT'S ACCOUNT NUMBER: PAPER
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.
34. PROF CD
35. CASE MANAGER ID

(9/10) EMEDNY-150003