

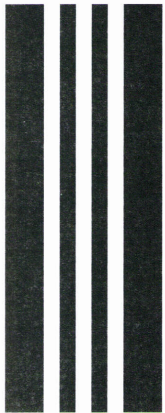
MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V
A 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 <input type="checkbox"/> FEMALE <input type="checkbox"/>		5A. PATIENT'S SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>		6A. MEDICAID NUMBER AB12345X	
			5B. PATIENT'S TELEPHONE NUMBER		6B. PRIVATE INSURANCE NUMBER		GROUP NO. RECIPROCALITY NO.	
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL			7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		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 <input checked="" type="checkbox"/> <input type="checkbox"/> CRIME VICTIM <input type="checkbox"/> AUTO ACCIDENT <input checked="" type="checkbox"/> <input type="checkbox"/> OTHER LIABILITY <input type="checkbox"/>		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 <input type="checkbox"/> NO <input type="checkbox"/>		16A. EMERGENCY RELATED YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. DATE PATIENT MAY RETURN TO WORK MM DD YY		18. DATES OF DISABILITY TOTAL PARTIAL FROM TO MM DD YY MM DD YY		
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Doctor's NAME				19A. ADDRESS (OR SIGNATURE SHF ONLY)				19B. PROF CD 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 <input type="checkbox"/> NO <input type="checkbox"/>		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										22F. POSSIBLE DISABILITY Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	22G. EPSDT C/THP Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	22H. FAMILY PLANNING Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
										23A. PRIOR APPROVAL NUMBER		23B. PAYMT 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 11/3/11	11	92340RB					Dx CODE	1	15.00		

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) Sign HERE			26. ACCEPT ASSIGNMENT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE 1500		28. AMOUNT PAID 000		29. BALANCE DUE 1500		
SIGNATURE OF PHYSICIAN OR SUPPLIER DR JAMES SMITH			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						
25A. PROVIDER IDENTIFICATION NUMBER OR OFFICE NPI			25C. LOCAL CODE 003		25D. SA EXCP CODE		32A. MY FEE HAS BEEN PAID YES <input type="checkbox"/> NO <input type="checkbox"/>		TELEPHONE NUMBER () EXT.		
COUNTY OF SUBMITTAL			25E. DATE SIGNED DATE		32. PATIENT'S ACCOUNT NUMBER PAPER		DO NOT WRITE IN THIS SPACE.				
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.			34. PROF CD		35. CASE MANAGER ID						