1500

ME

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 12345678A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe John

3. PATIENT'S BIRTH DATE MM 04 DD 08 YY 1950 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 47 State Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Brewer STATE: ME

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 044122135 TELEPHONE (Include Area Code): (207)555 1234

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 204.10

2. V707

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 13 11	09 13 11	22		99214	25	1 2	123 00	1		NPI	1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 000111000 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 123 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 123 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SMITH JOHN 09 30 2011

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

EASTERN MAINE MED CT
489 STATE STREET
BANGOR ME 044016616

a. b. 0000000011-001

33. BILLING PROVIDER INFO & PH # (207) 555-1212

DOCTORS MEDICAL OFFICE
43 MAIN STREET
BREWER ME 044121006

a. 1234567800 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-093-0999 FORM CMS-1500 (08/05)

Department of Health and Human Services
Integrated Access and Support Services
396 Griffin Road
11 State House Station
Bangor, Maine 04401-3095
Tel. (207) 561-4333; Fax (207) 561-4493
Toll Free (800) 432-7825; TTY (800) 606-0215

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

BILLING INFORMATION

DEPT. OF HEALTH & HUMAN SERVICES
FAMILY INDEPENDENCE
396 Griffin Road
Bangor, ME 04401
561-4333 OR 1-800-432-7825
Case Number: 12345678A

DOE, JOHN
47 Brimmer Street
Brewer, ME 04412

Date: December 3, 2011

MaineCare will pay a part of the medical bill listed below if it is allowed under the MaineCare Benefits Manual. You are responsible for part of the bill that MaineCare does not pay.

Patient's Name	: DOE, JOHN
Patient's Number (Program)	: 12345678A
Provider/Services	: ANY MAINE Hospital
Date(s) Services Provided	: September 13, 2011 – September 23, 2011
Total Bill	: $2,624.58
Patient's Responsibility	: $1,279.29

Give this letter to the provider of medical services. Show them your MaineCare Identification Card. This letter tells the provider to bill MaineCare for the rest of the bill. You or your insurance, if you have any, are responsible for the rest of the bill

INSTRUCTIONS TO PROVIDER OF MEDICAL SERVICES

The person named above is eligible for assistance. Please bill the Department of Health and Human Services on your usual invoice for covered services if payment is allowed under the MaineCare Benefits Manual. Bill only for covered services provided on the date(s) indicated above. You will be paid the rates allowed by MaineCare minus credits from patient and insurance, if applicable. Therefore, the payment you get may be less than the amount you bill.

PLEASE ATTACH A COPY OF THIS FORM TO YOUR INVOICE

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Spend Down Split Billing Form

Form

Spend Down Split Billing: This calculation sheet needs to be attached with the original Spend Down Letter, and accompany each claim being submitted. The breakdown of the member responsibility amount for each claim, needs to equal the total member responsibility on the original Spend Down Letter.

Facility Charges: (UB-04)

		Date of Service:
Provider Name:	Any Maine Hospital	From
Provider NPI:	1100110011	09 / 13 / 11
Member Name:	Doe, John	To
Member ID:	12345678A	09 / 23 / 11

Billed Amount: $2,501.58
Member Responsibility Amount: $1,279.29

Professional Charges: (CMS 1500)

		Date of Service:
Provider Name:	Doctors Medical Office	From
Provider NPI:	1234567800	09 / 13 / 11
Member Name:	Doe, John	To
Member ID:	12345678A	09 / 13 / 11

Billed Amount: $ 123.00
Member Responsibility Amount: -0-

Professional Charges: (CMS 1500)

		Date of Service:
Provider Name:	_____	From
Provider NPI:	_____	_____ / _____ / _____
Member Name:	_____	To
Member ID:	_____	_____ / _____ / _____

Billed Amount: _____
Member Responsibility Amount: _____