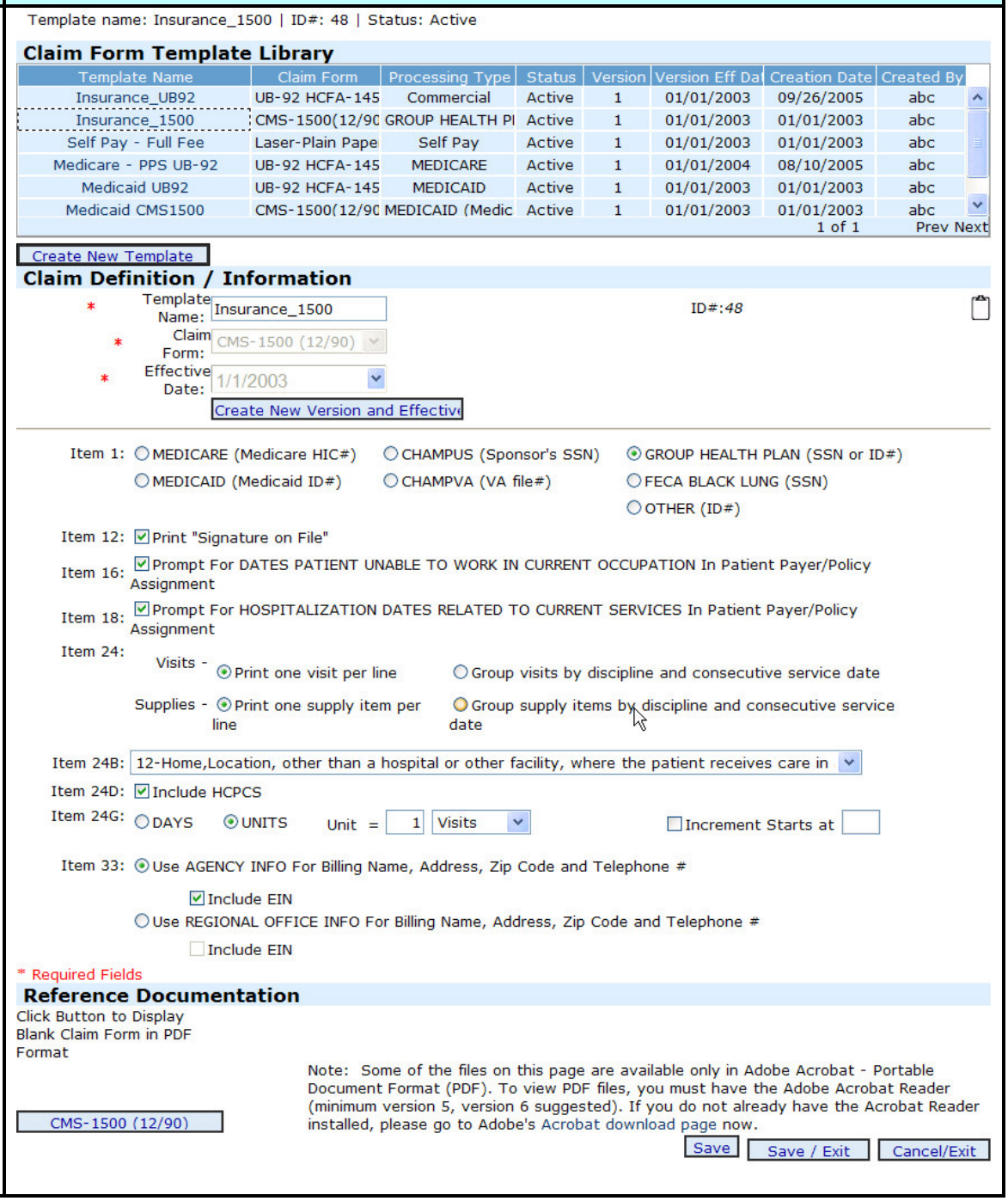
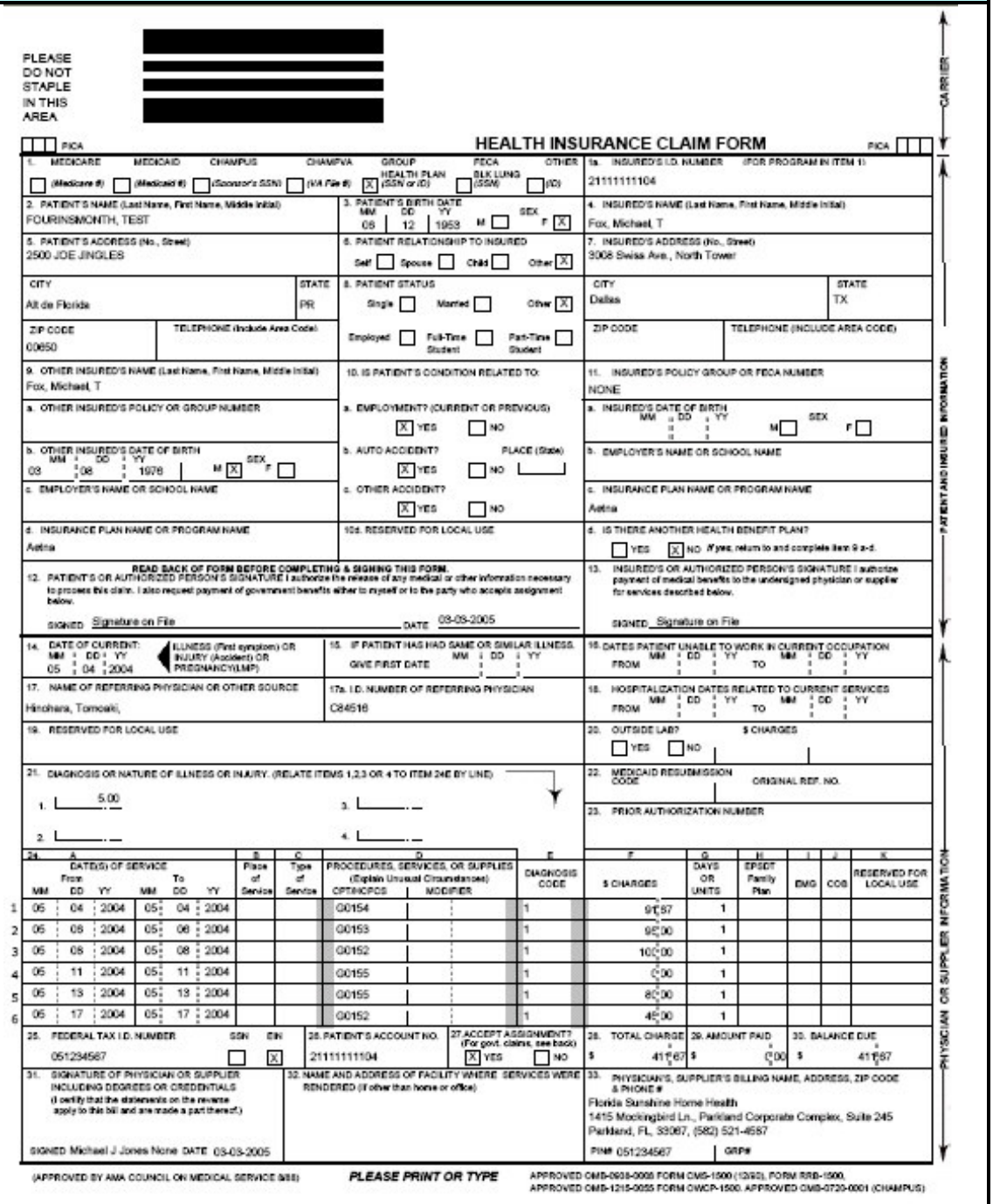
Instructions to customize claim form template – self pay invoice

Action / Instruction	Screen Shot
1. FINANCIAL – Billing – Claim Form Template Library: select an existing template to edit by clicking the hyperlink in the Template name column (or create a new one). Once selected, the claim form-specific customization fields are displayed in lower portion of screen.	

Action / Instruction	Screen Shot
2. sample self-pay invoice	

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FICA

HEALTH INSURANCE CLAIM FORM

FICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA / OTHER / BLK LUNG (SSN or ID) / (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 21111111104

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FOURINSMONTH, TEST

3. PATIENT'S BIRTH DATE: 08 / 12 / 1953 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Fox, Michael, T

5. PATIENT'S ADDRESS (No., Street): 2500 JOE JINGLES

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

7. INSURED'S ADDRESS (No., Street): 9008 Swiss Ave., North Tower

CITY: Alt de Florida — STATE: PR

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: Dallas — STATE: TX

ZIP CODE: 00850 — TELEPHONE (Include Area Code):

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE):

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Fox, Michael, T

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

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: 03 / 08 / 1978 — SEX: M [X] 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: Aetna

d. INSURANCE PLAN NAME OR PROGRAM NAME: Aetna

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] 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: Signature on File — DATE: 08-08-2005

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: Signature on File

14. DATE OF CURRENT: MM DD YY — 05 / 04 / 2004 — 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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Hirohara, Tomoaki,

17a. I.D. NUMBER OF REFERRING PHYSICIAN: C84516

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

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. 5.00
2.
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	05 04 2004 — 05 04 2004			G0154		1	91.67	1				
2	05 06 2004 — 05 06 2004			G0153		1	95.00	1				
3	05 08 2004 — 05 08 2004			G0152		1	100.00	1				
4	05 11 2004 — 05 11 2004			G0155		1	0.00	1				
5	05 13 2004 — 05 13 2004			G0155		1	80.00	1				
6	05 17 2004 — 05 17 2004			G0152		1	45.00	1				

25. FEDERAL TAX I.D. NUMBER: 051234567 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 21111111104

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

28. TOTAL CHARGE: $ 41.67

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 41.67

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.)

SIGNED: Michael J Jones None DATE: 08-08-2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:
Florida Sunshine Home Health
1415 Mockingbird Ln., Parkland Corporate Complex, Suite 245
Parkland, FL, 33067, (582) 521-4557

PIN# 051234567 — GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)