.....

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

471-000-58 Example of Form CMS-1500 version 02/012, "Health Insurance Claim Form"

Set Sporte Cold Cold Cold CODE TELEPHONE (Include Avec Code) THE A RESERVED FOR NUCC USE CITY STATE CODE TELEPHONE (Include Avec Code) THE A RESERVED FOR NUCC USE CITY STATE 2011/ER INSURED S NUME (Last Name, First Name, Model Initial) IL IS PATIENT S CONDITION RELATED TO: 11. INSURED S POLICY OR GROUP NUMBER I. INSURED S DATE OF BITH SEX 2011/ER INSURED S POLICY OR GROUP NUMBER IL IS PATIENT S CONDITION RELATED TO: 11. INSURED S DATE OF BITH SEX INSURANCE PLAN NAME ON PROGRAM NAME IL IS PATIENT S CONDITION RELATED TO: II. INSURED S DATE OF BITH SEX INSURANCE PLAN NAME ON PROGRAM NAME ID IS CLAIN CODES (Designand by NUCC) II. INSURED S ID IS OF BITH III. INSURED S ID IS OF BITH III. INSURED S ID IS OF BITH III. INSURED S ID IS OF BITH ANTO ACCOURSE ID IS OF BATE OF BITH ID IS OF BATE OF BITH III. INSURED S ID IS OF BITH IIII. INSURED S ID IS OF BITH IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		-	M FO								
LSEDCARE VEX.LINE COMMPYN SECURE OTHERN NUMBER (for Programmin Num the The Nume, Market part of the Number of Programmin Num the The Nume, Market part of the Number of Programmin Num the The Nume, Market part of the Nume, Nume, Part of the Nume, Nume, Nume, Part of the Nume, Nume, Part o			IT TEE (N	000) 0212							PICA
Janssen (and the second sec	TRICARE	-	CHAMPIA	GROU	ID EECA	COLUCE	1. INSTIGED'S ID N	INACO	And the second	AND INCOMENTS OF THE OWNER OWNE
ATTERT 3 BANK (LAN Nome, Part Name, Mode bank) 2 Particip Result (LAN Nome, Part Name, Mode bank) 2 Particip Result (LAN Nome, Prior Name, Mode bank) 2 Particip Result (LAN Nome, Prior Name, Mode bank) Y STATE 8 PATICIPY RELATIONSHED TO NUSCIPCO 7. HOLPEO'S NAME (LAN Name, Frain Name, Mode bank) Y STATE 8 RESERVED FOR NUSCI USE CrY STATE CODE TELEPHONE (Inclus A Name, Mode bank) 10. IS PATICIPY RELATIONSHED TO NUSCIPCO 11. HOLPEO'S NAME (LAN Name, Frain Name, Mode bank) 20. IS PATICIPY RELATIONSHED TO NUSCIPCO 11. HOLPEO'S NAME (LAN Name, Frain Name, Mode bank) CODE TELEPHONE (Inclus A Name, Mode bank) 10. IS PATICIPY RELATION RELATED TO: 11. HOLPEO'S NAME (LAN Name, Con Prior) 11. HOLPEO'S NAME (LAN Name, Con Prior) 20. IS PATICIPY RELATION RELATED TO: 11. HOLPEO'S NAME (LAN NAME CON PROCINA NAME ESERVED FOR NACC USE 0. OTHER ACCODENT 10. OTHER ACCODENT 11. HOLPEO'S NAME (DAN NAME 11. HOLPEO'S NAME (DAN NAME ESERVED FOR NACC USE 0. OTHER ACCODENT 10. OTHER ACCODENT TO MANKE 11. HOLPEO'S NAME (DAN NAME 11. HOLPEO'S NAME (DAN NAME FERE PACO FORM DECOLES 0. OTHER ACCODENT TO MAINTERNAL 10. OTHER ACCODENT TO MAINTERNAL 11. HOLPEO'S NAME (DAN NAME FERE PACO FORM DECOLES		-	Г	-	HEAL		JNG		ionio en		(i or i rogram in dani i t
ATIENT'S ADDRESS (No. Shwell IS PATENT'S ADDRESS (No. Shwell IS PATENT'S REATTORNEY TO NUBJERCE 7. HSUBECD S ADDRESS (No. Shwell Y IS PATENT'S REATTORNEY TO NUBJERCE CTY IS PATENT'S REATTORNEY TO NUBJERCE CTY IS PATENT'S REATTORNEY TO NUBJERCE Y IS PATENT'S CONCITION RELATE O IS PATENT'S CONCITION RELATE O IS PATENT'S CONCITION RELATE O CTY IS PATENT'S CONCITION RELATE O Y IS IS PATENT'S CONCITION RELATE O IS I	PATIENT'S NAME (Last Name, First	Name, Middle	Initial)	- L	3. PATIENTS	BIRTH DATE	SEX	4. INSURED'S NAME	(Last Name, Fir	si Name.	Middle Initial)
Set Spore Cete Cet Cete Cete <thc< td=""><td></td><td></td><td></td><td></td><td>MM D</td><td>M N</td><td>F</td><td></td><td></td><td></td><td></td></thc<>					MM D	M N	F				
Y STATE B RESERVED FOR NUCC USE CitY STATE 1200E TELEPHONE (Include Area Code) 20 <td>PATIENT'S ADDRESS (No , Street)</td> <td>the second of the second s</td> <td>and the second second second</td> <td></td> <td>6. PATIENT R</td> <td>ELATIONSHIP TO IN</td> <td>SURED</td> <td>7. INSURED'S ADDR</td> <td>ESS (No , Street</td> <td>)</td> <td>an an a</td>	PATIENT'S ADDRESS (No , Street)	the second of the second s	and the second second second		6. PATIENT R	ELATIONSHIP TO IN	SURED	7. INSURED'S ADDR	ESS (No , Street)	an a
CODE TELEPHONE (Incluse Area Code) China Processes and Code Processes					Self	Spouse Child	Other				
	ITY	North Contract Sectors (State		STATE	8. RESERVED	FOR NUCC USE		CITY	Transfer to the second second		STATE
											and the second second
ALTOR AND ALL STATUS ALL AND ALL	P CODE TEL	EPHONE (Inclu	ude Area	Code)				ZIP CODE	TE	EPHON	E (Include Area Code)
ALTOR AND ALL STATUS ALL AND ALL	(()								()
	OTHER INSURED'S NAME (Last Na	ime, First Name	a, Middle	Initial)	10. IS PATIEN	T'S CONDITION REI	ATED TO:	11. INSURED'S POLI	CY GROUP OR	FECA NL	MBER
			-								and the second second
EESERVED FOR NUCC USE	OTHER INSURED'S POLICY OR GI	ROUP NUMBER	a		a. EMPLOYM			a. INSURED'S DATE	OF BIRTH		remove process
	RESERVED FOR NUCCUSE				5 ALTO 100		0		-	li li	
ESERVED FOR NUCC USE SIGNATURE C. THER ACCIDENT? C. NSURANCE PLAN NAME OR PROGRAM NAME SIGNATURE SIGNATURE SIGNATURE C. NSURANCE PLAN NAME OR PROGRAM NAME SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATUR SIGNATUR SIGNATURE SIGNATUR SIGNATURE SIGNATU	TO DE LES CONTROLS USE				U. AUTO ACC			b. OTHER CLAIM ID	Designated by I	AUCC)	
YES NO ISTHERE AND THERE HEALTH BENEFIT PLANT YES NO ISTHERE AND THERE HEALTH BENEFIT PLANT NEXURANCE PLAN MANE 105. CLAIM CODES (Designated by NUCC) ISTHERE AND THERE HEALTH BENEFIT PLANT NEXURANCE PLAN MANE OF PORUS BERGER COMMENTING a SIGMATTRE I Induction the mission of an induction of an induction of an induction physican of a septient for before static description of an induction of an induction the mission of an induction the mission of an induction the mission of an induction of an induction of an induction physican of a septient for before static description of an induction physican of a septient for before static description of an induction of an induction of an induction of an induction physican of a septient for before static description of an induction	RESERVED FOR NUCC USE				C OTHER AC			C INSTRANCE DI AN	NAME OF BEE	CRAME	IAME
NSURANCE PLAN HAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d IS THERE ANOTHER HEALTH BENEFIT PLAN? READ BACK OF FORM BEFORE COMMENTATION (SIGNATURE I authorits the release of any medical or other kidomation necessary) 11 INSURED'S OF ANTOPRIZE PERSONS SIGNATURE I authorits the release of any medical or other kidomation necessary 11 INSURED'S OF ANTOPRIZE PERSONS SIGNATURE I authorits the release of any medical or other kidomation necessary VIENTE OF OUR DEFORM OF FORM DEFORE COMMENTATION (SIGNATURE I authorits the release of any medical or other kidomation necessary) 11 INSURED'S OF ANTOPRIZE PERSONS SIGNATURE I authorits the release of any medical or other kidomation necessary VIENTE OF OUR PERSONS SIGNATURE I authorits the release of any medical or other kidomation necessary 12 INSURED'S OF ANTOPRIZE PERSONS SIGNATURE I authorits the release of any medical or other kidomation necessary VIENTE OF OUR PERSONS SIGNATURE I AUTHORITIE TERMINE PROVIDER OR OTHER SOURCE OF THE ROUTER I COMMENT DATE DATE DATE SIGNED DATE MM DD YY NAME OF REFERRING PROVIDER OR OTHER SOURCE Trap (P) To A DDTE(S) OF SERVICE ROUTER OF ALLINESS OR INJURY MEDICE ID AUTHORIZATION NUMBER C D POINTER R A DD YY MM DD YY SCHARDES DIAGNOSIS OR NATURE OF ALLINESS OR INJURY MEDICES DIAGNOSIS OR NATURE OF SERVICE ROUTER TO AUTHORIZAT					C. OTHER AC		0	C. INSURANCE PLAN	NAME ON PAC	MAM N	I'M E
READ BACK OF PORM BEFORE COMPLETING & SIGNING THIS FORM. PATENT'S OR AUTHORIZED PERSONS SIGNATURE I enhances any mediation of the robustion necessary by process the claim. I also request payment of government benefits ather to mysalf or to the pay who accepts assignment bows SIGNED DATE	INSURANCE PLAN NAME OR PRO	GRAM NAME			10d. CLAIM C			d IS THERE ANOTHE	B HEALTH BE	EFIT P	AN?
IPED B DACK OF FORM BEFORE COMPLETIVE & BISCHNIC THE IP OND. 13. Inspired and an exact based and a submittance to the submittance and an exact of the planty who accepts assignment. 13. Inspired and an exact based the underlighted physician or supplier for services described below. SIGNED DATE SIGNED 14. Inspired and an exact based the underlighted physician or supplier for services described below. SIGNED DATE SIGNED SIGNED 16. ONTER PATENT UNDER PATENT VALUE VERS PATENT UNDER PATENT VALUE VERS PATENT VALUE VERS PATENT VALUE VERS PATENT VALUE VE					Con Constant C	- The featured of			1		
PATIENTS OR AUTHORIZED PERSON'S SIGNATURE Is subjects the relases of any medical or other information necessary before the relases of any medical or other information necessary before the relaxed before to government bearing to the party who accepts assignment to see understagened opysician or supplier for supplier to resolution of government bearing to the party who accepts assignment to the understagened opysician or supplier for supplier to resolution of government bearing to the party who accepts assignment to the understagened opysician or supplier for supplier to resolution of government bearing to the understagened opysician or supplier for supplier to resolution of government bearing to the understagened opysician or supplier to resolution of medical party supplier to resolution of medical party supplier to resolution of the resolution of government bearing to the understagened opysician or supplier to resolution of medical party supplier to resolution of government bearing to the understagened opysician or supplier to resolution of government bearing to the understagened opysician or supplier to resolution of medical party supplier to resolution of the resolution of government bearing to the understagened opysician or supplier to resolution of the resolution of	READ BAC	K OF FORM BE	FORE C	OMPLETING	& SIGNING TH	IS FORM					the second se
DATE OF CURRENT LUNESS, INJURY, or PREGNANCY (UMP) UAL UAL UAL UAL UAL UAL UAL UAL UAL UA	PATTENT'S OF AUTHORIZED PER to process this claim. I also request p below.	ISON'S SIGNA asyment of gove	TURE 1a	authorize the re enefits either to	elease of any m o myself or to th	edical or other informa e party who accepts a	ition necessary ssignment			undersig	ned physician or supplier for
DATE OF CURRENT SILVARESS, INJURY, or PREGNANCY (LMP) OUAL OUAL OUAL OUAL OUAL OUAL OUAL OUAL	SIGNED				DAT	E		SIGNED			
OUAL FROM TO NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17a 19. HOSPITAL2ATION DATES RELATED TO CURRENT SERVICES, VY ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES DIAGNOSIS OR NATURE OF ILLINESS OR INJURY Relate A-L to service line below (24E) ICD Ind 22. PERIOR AUTHORIZATION NUMBER DIAGNOSIS OR NATURE OF ILLINESS OR INJURY Relate A-L to service line below (24E) ICD Ind 22. PERIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE B. C L H L K L E FROM ORIGINAL REF NO 23. PRIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE B. C D. POONTER A DATE(S) OF SERVICE B. C D. POONTER S CHARGES M DD YY MM DD YY SERVICE B. C PROVIDER ID.9 FEDERAL TAX ID NUMBER 28. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT' 28. TOTAL CHARGE 29. AMOUNT PAID SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INP	DATE OF CURRENT ILLNESS, IN.	JURY, or PREG	NANCY	(LMP) 15. 0	THER DATE	and the second			UNABLE TO WO	ARK IN C	URRENT OCCUPATION
ADD YY MM DD YY MM DD YY ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ C LARGES \$ C L C C LARGES \$ C L C C C C C C C C C C C C C C C C C				QUA	L.	MM DD	YY		DYY		MM DD YY
I7b HPI FROM TO ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? S CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service into below (24E) ICD Ind 22 RESUBNISSION DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service into below (24E) ICD Ind 22 RESUBNISSION A DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES E A DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES E A DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES E M DD YY SEMORE C. D. PROCEDURES, SERVICES, OR SUPPLIES E F G. MARGES M DD YY SERVICE REMO CPITHEPCS MODIFIER POINTER S CHARGES NPI M DD YY SERVICE FACILITY S ACCOUNT NO. 27 ACCEPT ASSIGNMENT? 28 TOTAL CHARGE 28 AMOUNT PAID 30. Ravel for NUCC U YES MO S S S S S S S L ICUTIONA DEGREES OR CHEDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	NAME OF REFERRING PROVIDE	R OR OTHER S	OURCE	17a.	The lower	and the second	and the second	18. HOSPITALIZATIO	N DATES RELA	TED TO O	CURRENT SERVICES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) B				1	NPI						
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Retaile A-L to service line below (24E) L	ADDITIONAL CLAIM INFORMATIO	N (Designated	by NUCC)				20. OUTSIDE LAB?		\$ CI	HARGES
Louing B. C C O CODE ORIGINAL REF NO L F G. D C D 23. PRIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE B. C D. PROCEDURES, SERVICES, OR SUPPLIES E D D From To PUXCS C D. PROCEDURES, SERVICES, OR SUPPLIES E D MRS Provider ID. # I DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER S CHARGES MRS PROVIDER ID. # I DD YY MM DD YY SERVICE EMG POINTER S CHARGES MRS PROVIDER ID. # I DD YY MM DD YY SERVICE POINTER NPI NPI I DD YY MM DD YY S CHARGES MRS NPI I I I I I IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII									NO		1000
FEDERAL TAX 1.0 NUMBER SN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? PEDERAL TAX 1.0 NUMBER 28. TOTAL CHARGE 29. ADTE(S) PATIENT'S ACCOUNT NO. SIGNATURE OF PHYSICIAN OR SUPPLIER NCLUDING DEGREES OR CREDENTALS 23. SERVICE FACILITY LOCATION INFORMATION 23. BILLING PROVIDER INFO & PH # ()	DIAGNOSIS OR NATURE OF ILLN	ESS OR INJUR	IY Relate	e A-L to servic	e line below (2	4E) ICD Ind		22 RESUBMISSION CODE	, ORI	GINAL FI	EF NO
Image: Constraint of the system of the sy	B.			CL		- ° L.					
A DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES E E E D. DO D. DO YY MM DO YY MM DO YY SERVICE E E D. DO YY MM DO YY SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES E D. DO YY MM DO YY SERVICE EMG C.PT/HCPCS MODIFIER DIAGNOSIS S CHARGES MBR D. DO PROVIDER ID. # IDD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS S CHARGES IMBR DIAGNOSIS S CHARGES NPI NPI NPI NPI NPI NPI NPI NPI NPI FEDERAL TAX 1.D. NUMBER SSN EIN 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Ravd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # () Vorthy that the statements on the reverso 32. SERVICE FACILITY LOCATION INFORMATION <td< td=""><td>F. </td><td>L</td><td>and the second se</td><td>G. L</td><td></td><td>– ні</td><td></td><td>23. PRIOR AUTHORIZ</td><td>LA FION NUMBE</td><td>н</td><td></td></td<>	F.	L	and the second se	G. L		– ні		23. PRIOR AUTHORIZ	LA FION NUMBE	н	
From TO PUCC OF EMG (Explain Unusual Circumstances) DIAGNOSIS DIAGNOSIS <td></td> <td>an internet warmer of the lot of the party and</td> <td></td> <td>and we in some support of the local</td> <td></td> <td>Contraction of the local division of the loc</td> <td></td> <td></td> <td></td> <td></td> <td></td>		an internet warmer of the lot of the party and		and we in some support of the local		Contraction of the local division of the loc					
DD IT WM DD IT WM DD IT WM DDL PROVIDER ID.# NPI NPI NPI NPI NPI NPI NPI NPI NPI NPI NPI NPI NPI FEDERAL TAX I:D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Birg gow communication with backhing the backhing	From To	PLACE OF	F	(Explain	Unusual Circu	imstances)	DIAGNOSIS		DAYS UPSO	10.	
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? IFOR DAY LEADING HER DEDUCT 28. TOTAL CHARGE 29. AMOUNT PAID 30. Revel for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #)	A DD YY MM DD	YY SERVICE	EMG	CPT/HCPC	S	MODIFIER	POINTER	\$ CHARGES	UNITS Plan	OUAL	PROVIDER ID. #
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? IFOR DAY LEADING HER DEDUCT 28. TOTAL CHARGE 29. AMOUNT PAID 30. Revel for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #)			1	p	1				1000	-	
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 			-		21		-	L		NP1	AND THE REAL PROPERTY AND
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 			1		1		1	a set of the set	1 COL MARK	NPI	
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Exercise to body 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #)		1000					1	L			States of the second
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Exercise to body 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #)				1			1980 X157 14 11				a series of the series of the
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? EP or port cleaner, leed back/or VES 28. TOTAL CHARGE 29. AMOUNT PAID 30. Revd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER NCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()							10.20			NPL	
FEDERAL TAX 1.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Every on cleaned, lee back 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rovd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()							1		1	NPL	The second second
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29 AMOUNT PAID 30. Rovd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()								[
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? IFO grow. claims, see back: 28. TOTAL CHARGE 29 AMOUNT PAID 30. Rsvd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()								l			
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? IFO grow. claims, see back: 28. TOTAL CHARGE 29 AMOUNT PAID 30. Rsvd for NUCC U SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()										NPI	
IFOr powr. claining, siee back/orgeneration in the provided in the statements on the reverse If or powr. claining, siee back/orgeneration in the provided in the statements on the reverse \$ \$ Signature OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ())										NPI	
SIGNATURE OF PHYSICIAN OR SUPPLIER NICLUDING DEGREES OR CREDENTIALS (Cartify that the statements on the reverse										NPI	
INCLUDING DEGREES OR CREDENTIALS	FEDERAL TAX 1.D. NUMBER	SSN EIN	26. P	PATIENT'S AC		27 ACCEPT A	SSIGNMENT?	28. TOTAL CHARGE	29 AMO	NPI	D 30. Rsvd for NUCC U
(certify that the statements on the reverse	FEDERAL TAX 1.D. NUMBER	SSN EIN	26. P	PATIENT'S AC				r		NPI	D 30. Rsvd for NUCC U
appry in the one on one in the one of poil of the over	SIGNATURE OF PHYSICIAN OR S	UPPLIER				YES		5	s	NPI	D 30. Rsvd for NUCC U
	SIGNATURE OF PHYSICIAN OR S INCLUDING DEGREES OR CREDE (I certify that the statements on the r	UPPLIER ENTIALS everse				YES		5	s	NPI	D 30. Rsvd for NUCC U

REV. MARCH 1, 2014 MANUAL LETTER # 19-2014

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID SERVICES 471-000-58 Page 2 of 4

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any felse, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

REFERS TO GOVERNMENT PROGRAMS ONLY MEDICARE AND TRICARE PAYMENTS: A patient's signature requests their payment to make and authorizes release of only information necessary to process the claim and cartiles that he information provided in Blocks 1 through 12 is true, accurate and cartiles, in the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare claim and hommetical information and whether the person has employer group health insurance, liability, no-fault, worker's comparison or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If them 9 is completed, the patient's signature authorizes release of the information to the health plan or againery shown in Medicare assigned or TBICARE facel internetional to accept the charge detormination of the Medicare cartier or TBICARE is calinometicary if this is tess than the charge submitted. TBICARE is not a theight hometice program but makes upyment for health bunghs provided through cartain affinitions with the Internet Services. Inclusion carterial carterial assignment on the native structure carterial or TBICARE is not a theight insurance, and the isolation accurate and non-covered services. Communication and the accurate and non-covered services. Communication and the isolation isolation carteriate and the upon the charge determination of the Medicare carterial or TBICARE facel intermediary if this is tess than the charge outbanited. TBICARE is not a theight hometice program but makes upyment for health bunghs provided through cartain adjusted in the tradition and the isolation carterial intermediary if this is tess than the charge outbanited. TBICARE is not a the interim carterial to freshells through cartain adjusted isolation adjusted in the internet carterian adjusted isolation adjusted in the internet carterian adjusted isolation in the internet carterian adjusted isolation adjusted in the internet carterian adjusted isolation adjusted internet. The i with the Uniformed Services. Information on the patient's sponsor should be provided in those nems captioned in "Insured": i.e., items 1a, 4, 6, 7, 9 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis costing systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal fainds, I certify that 1) the information on this form is truth, accurate and complete, 2) I have familianzed myself with all applicable laws. In somitang this can be available tool the Medicare contracter; a) that we provided are will provide sufficient information requires an approximation and program matricina, which are available tool the Medicare contracter; a) that we provided are will provide sufficient information required a safety which are available tool the Medicare contracter; a) that we provided are will provide sufficient information required a safety which are available tool the Medicare contracter; a) that we provided are will provide sufficient information required and sufficient information required are approximate and program instructions for payment including but not thinked to the Federal anti-kickack statute and Physician Self-Referral law (commonly known as Stark tow). S) the sorrices and program instructions for payment including but not thinked to the Federal anti-kickack statute and Physician Self-Referral law (commonly known as Stark tow). S) the sorrices are modeled processary and personally lumished by me or were furnished incident to my professional service by my employee under my direct supervision, accept as otherwise expressive permitted by Medicare or TRICARE; 6) for each services reducer endered incident to my professional service. In eidenkity (legal name and NPI license #, or SSN) of the primary individual rendering explanations is trained incident to a physician's professional service. The density float and services of the primary individual rendering explanations are apprecised as the primary of the contered under the available tool to a physician's professional service. The physical services of the primary is condered and the primary of the pri physician's direct supervision by his/her employee, 2) they must be an integral, although incidential part of a covered physician service, 3) they must be of kinds commonly furniened in physician's offices, and 4) the survices of non-physicians must be included on the physician's bills.

For TRICARE claims. Further centify that I (or any employee) who randered services an not an active duly member of the Uniformad Services or a civilian employee of the Uniformation Services or a civilian employee of the Uniformation Services and Ser int or a contract employee of the United States Government, either civilian or military trefer to E USC 5528). For Black-Lung daims, I further contract the united states Government, either contract employee and the united states for a Black Lung-related disorder

No Part B Modicare benofits may be paid unloss this form is received as required by existing law and regulations (42 CFR 424 32).

NOTICE: Any one who misrepresents or faislifics essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Faderal laws.

and 1086: 5 USC 8101 et seq. and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, camers, intermediaries, medical review beards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other bird pantics payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the bonolds you have used to a hospital or doctor. Additional disclosures are made through routine uses for information excitant of systems of tocords

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carner Medicare Clauns Record," published in the Federal Register, Vol. 55 No. 177, page 37549. Wed. Sept. 12, 1390, or as updated and republished.

FOR OWCP CLAIMS: Department of Leber, Privacy Act of 1974, "Republication of Natice of Systems of Records," Federal Register Vot. 55 No. 40, Wod Fab. 28, 1990, See ESA-5. ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

---- FOR-TRICARE CLAIMS: PRINCIPLE PURPOSE(S)-To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and that the services/supplies received are authorized by faw

ROUTINELUSE(S), Information from claims and related documents may be given to the Dept. of Veterans Attains, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in ovel actions, to the Internal Revenue Service private collection agencies, and consumit reporting agencies in connection with recouptrient cierus; and to Congressional Offices in response to inquiries made at the request of the person to where a record pertains. Appropriate disclosures may be made to other federal state, local, totaign government agencies, private business enkloss and individual providers of cara, on matters celoting to entitlement, claims adjudication. Iraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and cval and criminal latigition related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no ponotices under these programs for rolating to supply information. However, failure to jurnish information regarding the modical services routdered or the ancient charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide modical information under FECA could be deemed an obstruction.

It is mandationy that you fell up it you know that enother party is responsible for paying for your treatment. Section 11288 of the Social Security Act and 31 USC 3801-3812 provide penalities for withholding this information

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches

MEDICAID PAYMENTS (PROVIDER CERTIFICATION) Thereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to lumish information regarding any payments claimed for providing such services as the State Agency or Dopt of Health and Human Services may request.

Hurther agree to accept, as payment in full, the amount paid by the Medicael program for these cleims submitted for payment under that program, with the exception of authorized deductible, e, co-payment or similar cost-shaling charge

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I canify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my percenal direction

NOTICE: This is to certify that the breasong information is true, occurate and camptete. Londerstand that payment and satisfaction of this claim will be from Foderal and State funds, and that any false dams, statements, or documents, or conceatment of n material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unlass it displays a valid GMB control number. The valid GMB control Rumber for this information collection is 0939-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to oviev instructions, search existing data resources, public the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time destinations for amyonic for amyoning this tomic tor CMS, 7300 Security Boulovard, Athin PRA Reports Concerne Officer. Mail Stop C4:28-05. Bollanore, Maryland 21244-1850. This address is for comments and/or suggestions only. Do NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

NEBRASKA DEPARTMENT OF MANUAL LETTER # 19-2014 HEALTH AND HUMAN SERVICES

471-000-58 Example of Form CMS-1500, "Health Insurance Claim Form"

Version 08/05, no longer accepted as of April 1, 2014

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05													
PICA													
MEDICARE MEDICALD TRICARE CHAMPVA (Medicare #) (Medicarid #) (Sponsor's SSN) (Member D	- HEALTH PLAN - PLKTUNG -	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)											
CITY STATE	Self Spouse Child Other 8. PATIENT STATUS	CITY	STATE Z										
	Single Married Other		<u>e</u>										
ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHON	E (Include Area Code)										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NU	JMBER N										
			8										
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY M											
b. OTHER INSURED'S DATE OF BIRTH SEX	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 N											
C. EMPLOTER 3 NAME ON SCHOOL NAME		6. INSURANCE FLAN NAME ON FROSHAM N	AN?										
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PL	AN?										
			o and complete item 9 a-d.										
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the n to process this claim. I also request payment of government benefits either t below.	elease of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S payment of medical benefits to the undersig services described below. 											
SIGNED	DATE	SIGNED	+										
14. DATE OF CURRENT: MM DO ILLUESS (First symptom) OR 15. II INUURY (Accident) OR 0 PEGGNARCY(LMP)	F PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	16. DATES PATIENT UNABLE TO WORK IN C MM DD YY TO											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO											
17b. 19. RESERVED FOR LOCAL USE	NPI	FROM TO 20. OUTSIDE LAB? \$ C	HARGES										
		YES NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE ORIGINAL R	EF. NO.										
1 3.	L '	23. PRIOR AUTHORIZATION NUMBER											
244	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I.											
	n Unusual Circumstances) DIAGNOSIS		AENDERING PROVIDER ID. # UNIVER										
			ULN OF N										
		NPI	E E										
		NPI	dd										
			BO										
			CIAN										
		NPI	sic										
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	CCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PA	ID 30. BALANCE DUE										
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FAC	YES NO	\$ \$ 33. BILLING PROVIDER INFO & PH # (l s										
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	ALLET COOVERNMENTON	20. DILLING PHOVIDEN INFO & PH #)										
apply to this bill and are made a part thereof.)													
a. NE	b	a. NPI b.											
SIGNED DATE ". INF			Ť										

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

REV. MARCH 1, 2014 MANUAL LETTER # 19-2014

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned CFR 411.24(a). The m9 is completed, the patient's signature authorizes release of the information to the headth plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT) (PRIVACY ACT STATEMENT) We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches. MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number of this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review for this information collection is observed. The time required to complete tim information released to average to very age to be accurately the time to review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.