

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										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 MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					CITY					STATE																								
ZIP CODE					TELEPHONE (Include Area Code)					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) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b> 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																														13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
_____ DATE _____															_____ SIGNED _____																								
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY															16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17a. _____															18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
17b. NPI _____															20. OUTSIDE LAB? \$ CHARGES																								
19. RESERVED FOR LOCAL USE																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)																																							
1. <u>xxx xx</u>										3. <u>V58 11</u>										2. <u>999 81</u>																			
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS																																							
1. <u>Jxxxx</u>										1										x xx x																			
2. <u>96xxx</u>										1										x xx x																			
3. <u>J1190</u>										2										x xx x																			
4. <u>xx xx xx xx xx xx 11</u>										2										x xx 2																			
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$																			
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & F																													

Item 21 - Diagnosis Code: Enter the ICD-9 code(s) that best describe the diagnosis, symptom or complaint for which the listed items or services were provided.

Item 24E - Diagnosis Pointer: Enter the line number from Item 21 that is the primary reason for the item or service reported on each line.

Item 24D - Drug Code: Enter HCPCS code J1190 (injection, dexrazoxane hydrochloride, per 250 mg) to report that TOTECT® was provided incident to a physician's service.

Item 24G - Days or Units for TOTECT® (J1190): Enter the number of 250 mg billing units (NOT THE NUMBER OF VIALS) used to treat the patient on the date of service. For example, if 2000 mg of TOTECT® is administered, then 8 billing units should be reported.

Item 24D - Drug Infusion Codes: In this example, TOTECT® is administered subsequent to the administration of other drugs on the same day. When that is the case, CPT code 96367 may be reported for each hour of TOTECT® infusion time.

Item 24G - Days or Units for Drug Administration: For CPT code 96367, enter 1 unit of administration time for each hour of TOTECT® infusion. In this example, infusion time was 2 hours, so 2 units are reported.