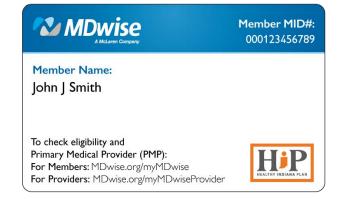
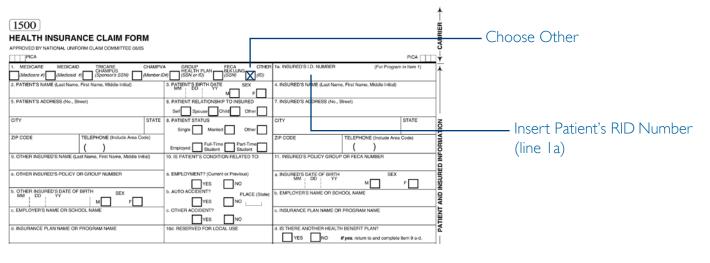
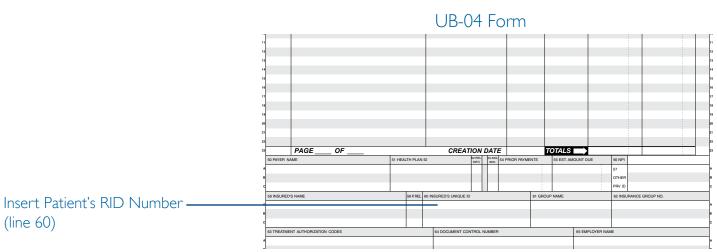


The instructions below shows what information should be filled in to specific blanks on the MDwise Healthy Indiana Plan Health Claim Forms.



Member ID Card





For complete instructions, please visit www.MDwise.org, choose HIP, Provider Relations, Claims.The full instructions are on the Claims page in PDF format for download.







## Highlighted Areas on the Forms Must Be Filled In

## 1500 **HEALTH INSURANCE CLAIM FORM** APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 PICA MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1) FECA BLK LUNG (Member ID#) (ID) (Medicare #) (Medicaid #) (Sponsor's SSN) rst Name, Middle Initial 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) Self Spouse Child Othe CITY STATE 8. PATIENT STATUS CITY STATE PATIENT AND INSURED INFORMATION Single Married ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) Full-Time Part-Time Student Employed Student 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 Not required a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES b. OTHER INSURED'S DATE OF BIRTH MM DD YY b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME YES NO c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES d. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 10d. RESERVED FOR LOCAL USE YES 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 | authorize the release of any medical or other information necessary. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION GIVE FIRST DATE 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES 22. MEDICAID RESUBMISSION 21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) ORIGINAL REF. NO 23. PRIOR AUTHORIZATION NUMBER DATE(S) OF SERVICE B. D. PROCEDURES, SERVICES, OR SUPPLIES PHYSICIAN OR SUPPLIER INFORMATION DIAGNOSIS RENDERING PLACE OF (Explain Unusual Circums \$ CHARGES **POINTER** PROVIDER ID. QUA NPI NPI 3 NPI NPI NPI 6 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE YES 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) a.

UB-04 Form

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