538/20 - Deer Park PLFASE APPROVED OMB-0938-0008 DO NOT **UFSD** P.O. Box 21157 **STAPLE** Eagan, MN 55121 IN THIS Client Number **AREA** 75034 Vision Claim Form PICA 1a. INSURED'S I.D. NUMBER MEDICARE CHAMPVA OTHER (FOR PROGRAM IN ITEM 1) **CHAMPUS MEDICAID** GROUP HEALTH PLA N FECA BLK LUNG (Medicare #) (Medicaid #) (Sponsor's (VA File (SSN or ID) (SSN) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 4. (NSURED'S NAME (Last Name, First Name, Middle Initial) М F 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. (NSURED'S ADDRESS (No., Street) Child Spouse Other CITY STATE STATE 8. PATIENT STATUS PATIENT AND INSURED INFORMATION Single Married Other ZIP CODE TELEPHONE (Include Area Code) TELEPHONE (INCLUDE AREA CODE) ZIP CODE Full-Time Part-Time Employed 9. OTHER INSURED NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. OTHER INSURED'S POLICY OR GROUP NUMBER a. INSURED'S DATE OF BIRTH MM | DD | YY SEX YES F b. OTHER INSURED'S DATE OF BIRTH b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME SEX F 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 NO If yes return to and complete item 9 a-d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medi alor other information necessary to process this claim. I also request payment of government benefit either to myself or to the party who for services described below. accepts assignment below. SIGNED DATE SIGNED 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS INJURY (Accident) OR GIVE FIRST DATE MM DD PREGNANCY (LMP) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN то FROM 20. OUTSIDE LAB? 19. RESERVED FOR LOCAL USE \$ CHARGES YES l No 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO TEM 24E BY LINE) 22. MEDICAID RESUBMISSION ORIGINAL REF. NO 23. PRIOR AUTHORIZATION NUMBER 2. 24. Α В С D Е F G Н J K PHYSICIAN OR SUPPLIER INFORMATION PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DAYS EPSD' DATE(S) OF SERVICE Place Туре DIAGNOSIS CODE RESERVED FOR \$ CHARGES EMG COB OR Family LOCAL USE MM DD MM חח CPT/HCPCS UNITS 29. AMOUNT PAID 25. FEDERAL TAX I.D. NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 30. BALANCE DUE SSN EIN □ NO YES \$ 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS RENDERED (If other than home or office) & PHONE # (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE PIN# GRP#

Client Name

Please send to:

Solstice