Print Form

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

Reset Form

1. Patient's Name (Last, First, MI)

2. Patient's birthdate/sex MM DD YY M F

3. Oregon Medicaid ID (include all letters & numbers)

4. Patient's address (number, street)

5. Patient's relation to insured Self Spouse Child Other

6. Insured's Name (Last, First, MI)

City State

7. Was condition related to:
a. Patient's employment Y N
b. Accident Auto Other

8. Insured's address (number, street)

ZIP code Phone (Area Code)

City State

9. Other insured's name (Last, First, MI)

a. Other insured's plan name

ZIP code Phone (Area Code)

Other insured's plan address (number, street)

b. Other insured's policy number

10. Insured's group # (or group name)

City State ZIP code Phone (Area Code)

12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

11. 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 *Date*

Signed (insured or authorized person)

13. Date of current: MM DD YY ◀ Illness (first symptom) or Injury (accident) or Pregnancy (LMP)

14. If emergency, check here

15. First date patient had same or similar illness MM DD YY

16. Name of referring provider or other source

16a.

16b. NPI

17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY

18. Outside lab? Yes No $ Charges

19. Prior authorization number

20. Hospitalization dates related to current services From MM DD YY To MM DD YY

21. Diagnosis or nature of illness or injury: Relate items A-L to service line below (22D)

A. B. C. D. E. F.

G. H. I. J. K. L.

22. A. Date(s) of service From MM DD YY To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis pointer	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
									OHA ID:
									NPI:
									OHA ID:
									NPI:
									OHA ID:
									NPI:
									OHA ID:
									NPI:
									OHA ID:
									NPI:
									OHA ID:
									NPI:

23. Federal Tax ID # SSN EIN

24. Total charge

25. Total Medicare payment

26. Patient's account #

27. Accept assignment? Y N

28. Ins (not Medicaid/Medicare)

29. Reserved

30. Service facility location information

NPI #: OHA #:

31. Billing provider information and phone number

NPI #: OHA #:

32. Provider certification

By completing this form and entering my provider identification, I certify that the statements on the reverse apply to this bill and are made a part thereof.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information to receive payment from federal funds requested by this form may be guilty of a criminal act punishable under the law and be subject to fine and imprisonment under applicable federal laws and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature request authorizes the payment be made, release of any information necessary to process the claim and certifies the information provided is true, accurate and complete. The patient's signature authorizes any entity medical, 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 service for which is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes the release of information to the health 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.

BLACK LUNG 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.

PROVIDER CERTIFICATIONS

FOR MEDICARE OR CHAMPUS PAYMENTS: I certify that the services shown on this form were medically indicated and necessary for the health of this 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 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 office, 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 or a contract 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. Unless this form is received as required by existing law and regulations (42 CFR 424.32).

FOR MEDICAID PAYMENTS: 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. 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 Department 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.

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 laws, funds and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable laws.

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

(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 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: PRINCIPAL 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 Department of Veterans Affairs, the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Department 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 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 of 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing date resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the CMS-1500 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 TO THIS ADDRESS.