

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPLUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFITTING <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small> | | | | 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 <input type="checkbox"/> M <input type="checkbox"/> F | | 1. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) | | | | 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 ZIP CODE TELEPHONE (INCLUDE AREA CODE) | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 11. 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> | | | |
| 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 below. SIGNED _____ DATE _____ | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits in the undersigned physician or supplier for services described below. SIGNED _____ DATE _____ | | 14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. RESERVED FOR LOCAL USE 20. OUTS OF POCKET? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____ | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTS OF POCKET? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER | | | |
| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCP/S MCDIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSO Family Plan I EMG J COB K RESERVED FOR LOCAL USE | | | | 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$ | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements or the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____ | | | | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP# | | | | | | | |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/68)

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 Printed on Recycled Paper

APPROVED OMB-3638-0008 FORM CMS-1500 (12-90), FORM RRB-1500
 APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPLUS)

Medical History/ Evaluation



Name: _____ Account #: _____ Date: _____

Ins. Type: _____

General Benefits: _____

Patient Responsibility: Copay: _____ Per: _____ Deductible: _____ % Responsible: _____

Referring Physician: _____ Family Physician: _____

Date of Injury/Onset: _____ Date of first Doctor Visit for this injury: _____

Current Work Status: _____ Last date worked due to this injury: _____

Level of Recreation: _____ Home/Travel concerns: _____

Is an Attorney involved in this case? YES NO

Have you had any other Diagnostic or Rehabilitative Services for this injury/episode? YES NO

If so, what type? (i.e., X-Rays, MRI, EMG, other) _____ When? _____

Have you had surgery for this injury? YES NO

Number of surgeries: 1 2 3 4 _____

Type of Surgery: _____ Date(s) of Surgery(ies) _____

Are you currently taking any prescription or non-prescription medications? YES NO

Anti-Inflammatories _____ List Other Medications: _____

Muscle Relaxers _____

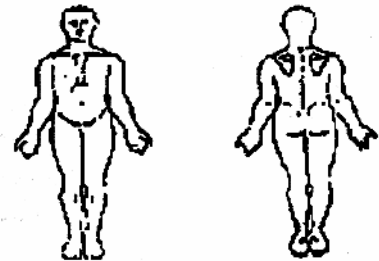
Pain Medication _____

How has pain changed since onset? _____

Indicate on Diagram where the pain is:

Do you now have or have you ever had any of the following?

| | YES | NO |
|-------------------------------------|-------|-------|
| Asthma, Bronchitis or Emphysema | _____ | _____ |
| Shortness of Breath/Chest Pain | _____ | _____ |
| Coronary Heart Disease or Angina | _____ | _____ |
| Do you have a Pacemaker | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| Heart Attack/Surgery | _____ | _____ |
| Stroke/TIA | _____ | _____ |
| Blood Clot/Emboli | _____ | _____ |
| Epilepsy/Seizures | _____ | _____ |
| Thyroid Trouble/Goiter | _____ | _____ |
| Anemia | _____ | _____ |
| Infectious Disease | _____ | _____ |
| Diabetes | _____ | _____ |
| Cancer or Chemotherapy/Radiation | _____ | _____ |
| Arthritis/Swollen Joints | _____ | _____ |
| Osteoporosis | _____ | _____ |
| Gout | _____ | _____ |
| Sleeping Problems/Difficulties | _____ | _____ |
| Emotional/Psychological problems | _____ | _____ |
| Bowel or Bladder Problems | _____ | _____ |
| Do You Smoke? _____ How much? _____ | _____ | _____ |
| Severe or Frequent Headaches | _____ | _____ |
| Vision or Hearing Difficulties | _____ | _____ |
| Numbness or Tingling | _____ | _____ |
| Dizziness or Faintness | _____ | _____ |



YES NO

Weakness _____

If so, where: _____

Weight Loss/Energy Loss _____

If so, where: _____

Hernia _____

Varicose Veins _____

Allergies _____

Any Pins or Metal Implants _____

Joint Replacement _____

Neck Injury/Surgery _____

Shoulder Injury/Surgery _____

Elbow Injury/Surgery _____

Back Injury/Surgery _____

Knee Injury/Surgery _____

Leg/Ankle/Foot Injury/Surgery _____

Are you Pregnant? _____

Alcohol Consumption? _____ How much? _____

List any other information that would assist us in your care: _____

Would you like to speak with a social worker or vocational counselor about these aspects of your rehabilitation program?

Are you aware of your Diagnosis? YES NO Arc you aware of your Prognosis? YES NO

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to _____ regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____