

P.O. Box 6018
Cleveland, Ohio 44101-1018

VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. SUBSCRIBER'S CERTIFICATE NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. SUBSCRIBER'S GROUP NO. RECIPROCITY ← N →
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.)	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
		11A. CHAMPUS SPONSOR'S STATUS <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED _____ DATE _____		

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>									
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____										
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____										
21. NUMBER AND NAME OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES										
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3 ETC. OR DX CODE			B. EPSDT YES <input type="checkbox"/> NO <input type="checkbox"/> FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO.										
			D ↓ DIAGNOSIS CODE										
24. A DATE OF SERVICE FROM TO		B PLACE OF SERVICE		C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (IDENTIFY PROCEDURE CODE) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		E CHARGES		F DAYS OR UNITS		G T.O.S		H M	
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PARTY THEREOF)				26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE		31. PHYSICIAN, SUPPLIER AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.	
				30. YOUR SOCIAL SECURITY NO.									
32. YOUR PATIENT'S ACCOUNT NO.				33. YOUR EMPLOYER ID NO.									

Signature of Physician (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PLACE OF SERVICE CODES:


- 1 – Inpatient Hospital
- 2 – Outpatient Hospital
- 3 – Doctor's Office
- 4 – Patient's Home
- 5 – Day Care Facility (PSY)
- 6 – Night Care Facility (PSY)
- 7 – Nursing Home
- 8 – Skilled Nursing Facility
- 9 – Ambulance
- 0 – Other Locations
- A – Independent Laboratory
- B – Ambulatory Surgical Center

- C – Residential Treatment Center
- D – Specialized Treatment Facility
- E – Comprehensive Outpatient Rehabilitation Facility
- F – Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 – Medical Care
- 2 – Surgery
- 3 – Consultation (Inpatient only)
- 4 – Diagnostic X-Ray
- 5 – Diagnostic Laboratory
- 6 – Radiation Therapy

- 7 – Anesthesia
- 8 – Assistant at Surgery
- 9 – Other Medical Service
- 0 – Blood or Packed Red Cells
- A – Used DME
- F – Ambulatory Surgical Center
- H – Hospice
- L – Renal Supplies in the Home
- M – Alternate Payment for Maintenance Dialysis
- N – Kidney Donor
- V – Pneumococcal Vaccine
- Y – Second Opinion on Elective Surgery
- Z – Third Opinion on Elective Surgery


MEDICAL MUTUAL
CAROLINA CARE PLAN | CONSUMERS LIFE

DOE, JOHN
Subscriber Name

123456789
Certificate Number

123ABC
Group Number

F 19 4.00/1.00 D 034 12-31-92
Rx TypeChd AgeDed AmtAg CdL Days SupplyExp Date



P.O. Box 6018
Cleveland, Ohio 44101-1018 8



VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. SUBSCRIBER'S CERTIFICATE NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. SUBSCRIBER'S GROUP NO. RECIPROcity ← N →
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.)	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
	11A. CHAMPUS SPONSOR'S STATUS <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED	