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P.O. Box 69314  
Harrisburg, PA  
17106-9314

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| MEDICAL INFORMATION                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | INSURANCE INFORMATION                                                                                                                                                |  |  |  |  |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| <b>1. PATIENT'S NAME (Last Name, First Name, Middle Initial)</b><br>Smith, Bob A.                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | <b>2. INSURED'S ID NUMBER</b><br>555-55-5555A                                                                                                                        |  |  |  |  |  |  |  |  |  |
| <b>3. PATIENT'S ADDRESS (incl. State)</b><br>123 Paradise Road<br>Seattle, WA 98101                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | <b>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</b><br>Same                                                                                             |  |  |  |  |  |  |  |  |  |
| <b>5. PATIENT'S DATE OF BIRTH</b><br>12/18/36                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | <b>6. INSURED'S ADDRESS (incl. State)</b><br>Same                                                                                                                    |  |  |  |  |  |  |  |  |  |
| <b>7. PATIENT'S RELATIONSHIP TO INSURED</b><br>Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>                                                                         |  |  |  |  |  |  |  |  |  | <b>7. CITY</b> _____ <b>8. STATE</b> _____                                                                                                                           |  |  |  |  |  |  |  |  |  |
| <b>9. PATIENT'S STATUS</b><br>Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                                      |  |  |  |  |  |  |  |  |  | <b>9. ZIP CODE</b> _____ <b>10. TELEPHONE (include Area Code)</b> _____                                                                                              |  |  |  |  |  |  |  |  |  |
| <b>11. EMPLOYMENT (Current or Previous)</b><br>Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/>                                      |  |  |  |  |  |  |  |  |  | <b>11. INSURED'S POLICY GROUP OR POLICY NUMBER</b><br>None                                                                                                           |  |  |  |  |  |  |  |  |  |
| <b>12. IS PATIENT'S CONDITION RELATED TO:</b><br>a. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>b. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>c. RESERVED FOR LOCAL USE |  |  |  |  |  |  |  |  |  | <b>12. INSURED'S DATE OF BIRTH</b> MM/YY <b>13. SEX</b> M <input type="checkbox"/> F <input type="checkbox"/>                                                        |  |  |  |  |  |  |  |  |  |
| <b>14. OTHER INSURED'S POLICY OR GROUP NUMBER</b> _____                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | <b>14. EMPLOYER'S NAME OR SCHOOL NAME</b> _____                                                                                                                      |  |  |  |  |  |  |  |  |  |
| <b>15. OTHER INSURED'S DATE OF BIRTH</b> MM/YY <b>16. SEX</b> M <input type="checkbox"/> F <input type="checkbox"/>                                                                                                                                           |  |  |  |  |  |  |  |  |  | <b>15. INSURANCE PLAN NAME OR PROGRAM NAME</b> _____                                                                                                                 |  |  |  |  |  |  |  |  |  |
| <b>17. EMPLOYER'S NAME OR SCHOOL NAME</b> _____                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | <b>16. IS THERE ANOTHER HEALTH BENEFIT PLAN?</b><br><input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 3 a-d</i>        |  |  |  |  |  |  |  |  |  |
| <b>18. INSURANCE PLAN NAME OR PROGRAM NAME</b> _____                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | <b>17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize payment of medical benefits to the undersigned physician or supplier for services described below. |  |  |  |  |  |  |  |  |  |
| <b>19. READ BACK OF FORM BEFORE COMPLETING &amp; SENDING THIS FORM.</b>                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |
| <b>20. SIGNATURE ON FILE</b> _____ <b>21. DATE</b> 02/14/2006                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | <b>22. SIGNATURE</b> _____                                                                                                                                           |  |  |  |  |  |  |  |  |  |
| <b>23. DATE OF CURRENT ILLNESS</b> (First signature of illness, address or procedure) _____                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | <b>24. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</b> (Give First Date) _____                                                                                        |  |  |  |  |  |  |  |  |  |
| <b>25. NAME OF REFERRING PROVIDER OR OTHER SOURCE</b><br>K. Brown, MD                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | <b>26. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</b><br>FROM MM/YY TO MM/YY                                                                                  |  |  |  |  |  |  |  |  |  |
| <b>27. RESERVED FOR LOCAL USE</b>                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | <b>27. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</b><br>FROM MM/YY TO MM/YY                                                                                  |  |  |  |  |  |  |  |  |  |
| <b>28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</b> (Please name I.C.D. 9 or 4 to item 245 by line)                                                                                                                                                           |  |  |  |  |  |  |  |  |  | <b>28. OUTSIDE LAB &amp; CHARGES</b><br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                          |  |  |  |  |  |  |  |  |  |
| <b>29. 250.00</b>                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | <b>29. MEDICAL PRESCRIPTION</b> _____ <b>ORIGINAL REF. NO.</b> _____                                                                                                 |  |  |  |  |  |  |  |  |  |
| <b>30. V58.61</b>                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | <b>30. PRIOR AUTHORIZATION NUMBER</b><br>50D000000000                                                                                                                |  |  |  |  |  |  |  |  |  |
| <b>31. DATES OF SERVICE</b> From MM/YY To MM/YY <b>32. PLACE OF SERVICE</b> <b>33. PROCEDURE, SERVICE, OR SUPPLY</b> (Explain Unusual Circumstances) <b>34. CHARGES</b>                                                                                       |  |  |  |  |  |  |  |  |  | <b>35. CHARGES</b> <b>36. CO-INSURANCE</b> <b>37. DEDUCTIBLE</b> <b>38. BALANCE DUE</b>                                                                              |  |  |  |  |  |  |  |  |  |
| 02/05/06 02/05/06 11 99212 1, 2 55.00 1 APR 3322221111                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |
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| <b>39. FEDERAL TAX ID NUMBER</b> 99-1234567 <b>40. SSN, EIN</b> <input type="checkbox"/> <input checked="" type="checkbox"/>                                                                                                                                  |  |  |  |  |  |  |  |  |  | <b>41. PATIENT'S ACCOUNT NO.</b> 123456789 <b>42. ACCEPT ASSIGNMENT?</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                         |  |  |  |  |  |  |  |  |  |
| <b>43. SIGNATURE OF PHYSICIAN OR SUPPLIER</b> INCLUDING DEGREE(S) OR CREDENTIALS (Specify that the statement on the reverse apply to this bill and are made a part thereof)<br>T. Jones 02/14/06                                                              |  |  |  |  |  |  |  |  |  | <b>44. SERVICE FACILITY LOCATION INFORMATION</b><br>Office Name<br>123 Main St.<br>Seattle, WA 98101-2345<br>* 1123456789                                            |  |  |  |  |  |  |  |  |  |
| <b>45. TOTAL CHARGE</b> \$ 115.00 <b>46. AMOUNT PAID</b> \$ 0.00 <b>47. BALANCE DUE</b> \$ 115.00                                                                                                                                                             |  |  |  |  |  |  |  |  |  | <b>48. BILLING PROVIDER INFO &amp; P.O. #</b> (555) 555-5555<br>Provider Name<br>P.O. Box 12345<br>Seattle, WA 98101-2345<br>* 1111222233                            |  |  |  |  |  |  |  |  |  |

Full-text: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1301000/>

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# Place Of Service Codes For Hcfa 1500

**Marilyn Fordney**



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Federal Black Lung Program Provider Manual ,1990      *Statistical Aspects of Physician Payment Systems* United States. National Committee on Vital and Health Statistics,1987      **Jones & Bartlett Learning's Administrative Medical Assisting** Julie Ledbetter,2020-04-27 Designed to ensure that every medical assisting graduate can quickly trade a cap and gown for a set of scrubs Jones Bartlett Learning s Administrative Medical Assisting Fourth Edition is more than just a textbook it s an engaging dynamic suite of learning resources designed to train medical assisting students in the administrative skills they ll need in today s rapidly changing health care environment      **Vital and Health Statistics** ,1965

Medical Insurance in a Flash! Alice Anne Andress,2011-01-04 Mastering medical insurance and coding made fun and simple This easy to follow traditional approach meets the needs of all learning styles with a visually rich text with perforated tear out flash cards      Jones & Bartlett Learning's Comprehensive Medical Assisting Judy Kronenberger,Julie Ledbetter,2020-05-07 Designed to ensure that every medical assisting graduate can quickly trade a cap and gown for a set of scrubs Jones Bartlett Learning s Comprehensive Medical Assisting Fifth Edition is more than just a textbook it s an engaging dynamic suite of learning resources designed to train medical assisting students in the administrative and clinical skills they ll need in today s rapidly changing health care environment The Fifth Edition includes a full chapter on Emergency Preparedness new in book role playing activities and an expanded array of online resources We re pleased to offer case studies skills videos and animations as part of our ancillary suite      **Administrative Healthcare Data** Craig Dickstein,Renu Gehring,2014-10 Explains the source and content of administrative healthcare data which is the product of financial reimbursement for healthcare services The book integrates the business knowledge of healthcare data with practical and pertinent case studies as shown in SAS Enterprise Guide      *Federal Register* ,2013-12      *Insurance Handbook for the Medical Office* Marilyn Fordney,2015-11-26 Stay up on the latest in insurance billing and coding with Marilyn Fordney s Insurance Handbook for the Medical Office 14th Edition Trusted for more than 30 years this market leading handbook equips you to succeed as medical insurance specialist in any of today s outpatient settings Coverage emphasizes the role of the medical insurance specialist in areas such as diagnostic coding procedural coding Medicare HIPAA and bill collection strategies As with previous editions all the plans that are most commonly encountered in clinics and physicians offices are incorporated into the text as well as icons for different types of payers lists of key abbreviations and numerous practice exercises that assist you in accurately filling out claim forms This new edition also features expanded coverage of ICD 10 electronic medical records electronic claims submission and the HIPAA 5010 keeping you one step ahead of the latest practices and protocols of the profession Key terms are defined and emphasized throughout the text to reinforce understanding of new concepts and terminology Separate chapter on HIPAA Compliance in Insurance Billing as well as Compliance Alerts throughout the text highlights important HIPAA compliance issues to ensure readers are compliant with

the latest regulations Emphasis on the business of running a medical office and the importance of the medical insurance specialist details the importance of the medical insurance specialist in the business of the medical office Increased focus on electronic filing claims submission prepares readers for the industry wide transition to electronic claims submission Separate chapter on documentation in the medical office covers the principles of medical documentation and the rationales for it Service to Patient features in most chapters offer examples of good customer service User resources on the Evolve companion website feature performance checklists self assessment quizzes the Student Software Challenge with cases on different payer types and an interactive CMS 1500 02 12 form to fill in NEW Expanded coverage of ICD 10 prepares users to code ICD 10 with the planned effective date of October 2015 NEW Added information on the electronic medical record and electronic claims submission including information on the HIPAA 5010 equips users for the transition between paper and electronic methods of medical records and links the CMS 1500 02 12 form to the electronic submissions process NEW SimChart for the Medical Office SCMO application activities on the companion Evolve website adds additional functionality to the insurance module on the SCMO roadmap     Handling the Medical Claim Catherine Cochran,2017-07-27 When a doctor sees a patient how does the doctor s office get paid If a claim for a service or procedure provided is denied how does the doctor s office get the patient s insurance company to pay Handling the Medical Claim An 8 Step Guide on How To Correct and Resolve Claim Issues explains from beginning to end how to bill and collect on cla

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