

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123-45-6789									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Jane N					3. PATIENT'S BIRTH DATE MM DD YY 01 01 19XX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, Jane N									
5. PATIENT'S ADDRESS (No., Street) 123 Main Street					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 Main Street									
CITY Anytown			STATE USA		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY Anytown			STATE USA						
ZIP CODE 12345			TELEPHONE (Include Area Code) (203) 555-1234		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME			d. 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>						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										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 _____					SIGNED _____ DATE _____					SIGNED _____ DATE _____									
14. DATE OF CURRENT: MM DD YY 01 01 2009					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE					17b. NPI					20. OUTSIDE LAB? \$ 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)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER				
1. <b>366.xx</b>										3. _____					F. \$ CHARGES				
2. <b>367.2x</b>										4. _____					G. DAYS OR UNITS				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE					C. EMG				
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER					H. EPSDT Family Plan				
1 07 31 09 07 31 09 24 66984 RT or LT 1 XXX XX										2 07 31 09 07 31 09 24 V2787 GY 2 XX XX					I. ID. QUAL.				
3 _____										4 _____					J. RENDERING PROVIDER ID. #				
5 _____										6 _____					25. FEDERAL TAX I.D. NUMBER SSN EIN				
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. 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 on the reverse apply to this bill and _____)				
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROC					NOTE: CMS does not require non-covered services to be listed on the claim form. The code recommended above should be used if a patient requests a denial and/or for facility tracking of non-covered charges. <sup>1</sup>				
SIGNED _____ DATE _____					a. NPI					b. NPI									

V2787 (Astigmatism correcting function of intraocular lens) is a new code as of January 2008.

Modifier GY - (Item or service statutorily excluded or does not meet the definition of any Medicare benefit).

Non-covered charges - Facility charge for surgery with IQ Toric IOL MINUS facility charge for surgery with conventional IOL EQUALS patient payment.

Diagnosis pointer indicates astigmatism.

<sup>1</sup>www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf

**Red: required**  
**Blue: if requested by the patient**

Information contained in this document is provided as a reference for providers in obtaining appropriate and accurate reimbursement. Content within the document is for information purposes only. Alcon does not guarantee that the use of the recommended codes will result in reimbursement. Providers may always contact the payer directly in regards to any reimbursement or billing questions.

