2017 Claim Form

1. Choose one:
☐ Family Planning Program: XIX
☐ DSHS Family Planning Program (DFPP)

1a. DFPP only:
☐ Partial Pay
☐ No Pay

2a. Billing Provider TPI: 1234567-89

2b. Billing provider NPI: 9768450132

3. Provider Name: Smith, Joe

4. Eligibility Date (MM/DD/CCYY): 01/02/2016

5. DSHS Client No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial): Doe, Jane

7. Address (Street, City, State): 341 Tosca Way, Houston, TX

7a. ZIP Code: 77485

8. County of Residence: Harris

9. Date of Birth (MM/DD/CCYY): 02/02/1981

10. Sex: ☒ F ☐ M

11. Patient Status: ☒ New Patient ☐ Established Patient

12. Patient's Social Security Number: 123 - 456 - 7089

13. Race (Code No.): 1
White (1) Asian (5) Black (2) Unk/Not Rep (6) AmIndian/AlaskNat (4) NatHawaii/PacIsland (7) More than one race (8)

13a. Ethnicity: 0
Hispanic (5) Non-Hispanic (0)

14. Marital Status: 3
(1) Married (2) Never Married (3) Formerly Married

15. Family Income (All): $

15a. Family Size: 2

16. Number Times Pregnant: 1

17. Number Live Births: 1

18. Number Living Children: 1

19. Primary Birth Control Method Before Initial Visit: G

20. Primary Birth Control Method at End of this Visit: A

a=Oral Contraceptive
b=1-Month hormonal injection
c=3-Month hormonal injection
d=Cervical cap/diaphragm
e=Abstinence
f= Hormonal Implant
g=Male condom
h=Female condom
i=Hormonal/ Contraceptive patch
j=Spermicide (used alone)
k=Intrauterine device (IUD)
l=Vaginal ring
m=Fertility awareness method (FAM)
n=Sterilization
o=Contraceptive sponge
p=Other method /Withdrawal
q=Method unknown
r=No method (if used for No. 20, must complete No. 21)

21. If No Method Used at End of This Visit, Give Reason (Required only if No. 20 = r)
a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Prg; e=Infertile; f=Rely on Partner; g=Medical

22. Is There Other Insurance Available?
☐ Y (If Y, Complete Items 23-25a.) ☐ N

23. Other Insurance Name and Address

24a. Insured's Policy/Group No.

24b. Benefit Code

25. Other Insurance Pd. Amt. $

25a. Date of Notification

26. Name of Referring Provider

27a. Referring Other ID

27b. Referring NPI

28. Level of Practitioner
☐ Physician ☐ Nurse ☐ Mid-Level ☐ Other

29. Diagnosis Code (Relate A-L to service line 32E) ICD Ind. 0
A. Z3009 B. ____ C. ____ D. ____
E. ____ F. ____ G. ____ H. ____
I. ____ J. ____ K. ____ L. ____

30. Authorization Number

31. Date of Occurrence (MM/DD/CCYY)

32.

	A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Ex. Ref. (29)	F Units or Days (Quantity)	G $ Charges		H Performing Provider No.
1															TPI
	01	02	2016	01	02	2016	1	1	99203	FP	1	1	$48	27	NPI
2															TPI
															NPI
3															TPI
															NPI
4															TPI
															NPI
5															TPI
															NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed $

36. **Total Charges** $48.27

37. Signature of Physician or Supplier
Date: 01/02/2016
Signed: Joe Smith

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

38a. NPI

38b. Other ID

39. Physician's, Supplier's Billing Name, Address, ZIP Code & Phone No.
Joe Smith
1234 Oak Drive
Houston, Texas 77485