INTAKE PACKET

Please fill out this packet as completely as possible. This information will assist in the evaluation process. Please bring the completed packet with you the day of the initial evaluation.

NOTE: ALL INFORMATION PROVIDED IS KEPT CONFIDENTIAL

Person completing the Intake Packet: _____

Relation to patient: _____

Patient Information:

Child's Name: _____ DOB: _____

Nickname / Goes by: _____

Address: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Responsible Party Information:

Guarantor's Name: _____ DOB: _____

Social Security #: _____ Relation to patient: _____

Address if different than patient: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Employer: _____ Phone: (____) _____

Emergency Contact Information:

Name: _____ Relation: _____

Address: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Insurance Information:

Primary Insurance Name: _____

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Relation to patient: _____

Secondary Insurance Name: _____

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Relation to patient: _____

Family History:

Father's Name: _____ DOB: _____

Place of Employment: _____ Phone: (____) _____

Occupation: _____ Highest Grade Completed: _____

Mother's Name: _____ DOB: _____

Place of Employment: _____ Phone: (____) _____

Occupation: _____ Highest Grade Completed: _____

If parents do not live together, describe custody arrangements: _____

_____

Child is our: Biological _____ Adopted _____ Foster Child _____

Siblings:

Name	Age	M / F	Speech, Hearing, or Medical Conditions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____

Pregnancy / Birth History:

Did mother have any of the following during the pregnancy?

Bleeding	_____	Virus Infection	_____	Accident	_____
Swelling	_____	Rubella	_____	Surgeries	_____
High Blood Pressure	_____	Diabetes	_____	Smoking	_____
Low Blood Pressure	_____	Asthma	_____	Toxemia	_____
Heart Condition	_____	Convulsions	_____	X-Ray	_____
RH Negative	_____	Anesthesia	_____		
Kidney Disease	_____	Excessive Weight Gain/Loss		____	
Alcohol Consumption	_____	Thyroid Condition	_____		

If yes, provide additional information: Which week/month of gestation? Was hospitalization necessary? _____

_____

Did mother take any medications during the pregnancy? If yes, which medications? _____

_____

What was the length of the pregnancy? _____

What was the length of hard labor? _____

Type of delivery (circle one):

vertex (head presentation) breech cesarean dry other

Were there any unusual problems at birth? _____ If so, describe: _____

_____

Birth Weight: _____ Apgar score at 1 minute: _____ at 5 minutes: _____

Were there any health problems during the first two weeks of infant life?

Jaundice	_____	Transfusions	_____	Hemorrhage	_____
Blueness	_____	Feeding Difficulty	_____	Tube Fed	_____
Breathing Difficulty	_____	Oxygen	_____	Convulsions	_____
Incubator or Isolate	_____	For how long	_____		

Was the first cry: strong _____ weak _____ high _____

Were intravenous or intramuscular fluids required? _____

How long did the child remain in the hospital? _____ Mother? _____

Is there any additional information regarding mother or baby during pregnancy and delivery that would help us to evaluate the child? _____

_____

Medical History:

Has the child have any of the following illnesses, surgeries, or injuries? If yes, please note at what age and the severity.

Whooping cough _____ Ear Infections _____

Mumps _____ Draining Ears _____

Scarlet Fever _____ PE Tubes Inserted _____

Measles_____ Tonsillectomy _____

Chicken Pox _____ Adenoidectomy _____

Pneumonia _____ Allergies _____

Diphtheria _____ Epilepsy _____

Croup _____ Encephalitis _____

Influenza _____ Typhoid _____

Headaches _____ Tonsillitis _____

Sinus problems _____ Chronic Colds _____

Meningitis _____ Head Injury _____

Rickets _____ Mastoidectomy _____

Rheumatic Fever _____ Asthma _____

Polio _____ Dental problems _____

Please describe any other operations or medical conditions your child has had that are not listed above: _____

_____

Pediatrician Name: _____ Office Phone: (_____) _____

List all doctors the child sees routinely: _____

_____

List all current medications your child is currently taking, both prescription and over the counter:

_____

Does your child have any seizure conditions? _____ Under what conditions? _____

_____

Is there any additional medical information that you feel would help with evaluating the child? _____

_____

Developmental History:

Has your child ever had ABA, speech/language, or occupational therapy in the past? Yes / No

If so, what type of therapy and when? _____

Where was therapy received? _____

Reason(s) for therapy: _____ Goals achieved? Yes / No

What is the primary language spoken in the home? _____

Are there any additional languages spoken in the home? _____

At what age did your child say his/her first word? _____

At what age did he/she use 2-word phrases? _____

At what age did he/she use sentences? _____

Has speech/language ever seemed to stop or decrease for a period of time? _____

If so, please describe: _____

How well can the child be understood by immediate family? _____

How well can the child be understood by others? _____

Which ONE does your child use most often? (circle one)

Sentences Phrases One or two words Sounds Gestures

Do you question your child's ability to understand directions and/or conversations? _____

If so, why? _____

Does your child hesitate, "get stuck", repeat, or stutter on sounds or words? _____

If so, describe: _____

Can your child read? _____ At what age did he/she begin reading? _____

Does your child's voice sound hoarse? _____ Low-Pitched? _____ Nasal? _____

Do you think your child hears adequately? _____

Do you think his/her hearing ability varies from day to day? _____

Has your child's hearing been checked recently? _____ What were the results? _____

_____

Note the ages that the following occurred:

Hold head erect	_____	Crawl	_____
Follow object with eyes	_____	Feed self with spoon	_____
Roll from back to stomach	_____	Sit unsupported	_____
Reach for objects	_____	Stand alone	_____
Dress self	_____	Walk alone	_____
Toilet trained	_____		

Is there any additional developmental information that you feel would help with evaluating the child? _____

_____

School Age History:

Preschool: _____ Age level/Teacher: _____

School: _____ Grade/Teacher: _____

Describe your child's typical grades / reports from the school: _____

_____

What concerns do you or the school have regarding school performance? _____

_____

Regarding attention/concentration? _____

Regarding work habits? _____

Regarding behavior? _____

Does your child receive special education services at school? Yes / No

What services are received? _____

Does your child have an IEP? Yes / No What is the date of the last IEP? _____

Is there any additional school related information that you feel would help with evaluating the child? _____

_____

Associated Services:

Intelligence testing: Yes / No Date: _____ Where: _____

Results: _____

Neurologic testing: Yes / No Date: _____ Where: _____

Results: _____

Psychological testing: Yes / No Date: _____ Where: _____

Results: _____

Physical Therapy evaluation: Yes / No Date: _____

Where: _____

Results: _____

Occupational Therapy evaluation: Yes / No Date: _____

Where: _____

Results: _____

Speech/Language Therapy evaluation: Yes / No Date: _____

Where: _____

Results: _____

Please bring copies of any evaluation reports to your evaluation appointment

Additional Background Information:

Describe your main concerns: _____

_____

_____

_____

When were concerns first noticed? _____ By whom? _____

What changes in your child's development and/or behavior have you noticed since that time? _____

_____

_____

_____

_____

List the people / organizations that you have consulted about the concerns:

Date Name / Address Outcome

_____ _____ - _____

_____ _____ - _____

_____ _____ - _____

AREAS OF CONCERN

____ Difficulty swallowing

____ Mouthing objects inappropriately

____ Excessive drooling

____ Biting, pinching, etc.

____ Uses only 1-2 words

____ Refusal to obey

____ Echolalia

____ Stuttering

____Poor sentence structure

____ Difficulty answering questions

____ Numerous ear infections

____ Misarticulating of words

____ Seizure activity

____ Impulsiveness

____ Difficulty with change

____ Dislikes being touched

____ Places self in dangerous situations

____ Clumsy, trips often

____ Weakness in arms, legs, trunk

____ Poor balance

____ Unable to catch tossed ball

____ Toe-walks

____ Spins inappropriately

____ Poor handwriting

____ Poor hygiene

____ Uses one hand more than other hand

____ Difficulty chewing food

____ Picky eater

____ Inappropriate toy play

____ Does not understand simple directions

____ Difficulty sleeping

____ Runs from parents, teachers, etc.

____ Distractibility

____ Poor/inappropriate eye contact

____ Pronoun misuse

____ Poor social interaction

____ Delay in sitting up

____ No verbal language

____ Bedwetting

____ Thumb sucking

____ Fixates on television/videos

____ Dislikes malls, shopping centers, etc.

____Delay in pulling up, crawling

____ Poor eye-hand coordination

____ Unable to ride bicycle

____ Fear of swings, playground equipment

____ Increased muscle tone in arms, legs

____ Lines up objects

____ Weak hand muscles

____ Unable to dress/undress self

____ Unable to skip or hop on one foot

____ Cannot feed self independently

AREAS OF CONCERN

____ Strong gag reflex

____ Difficulty climbing stairs

____Uncoordinated running pattern

____ Intolerant to textures

____ Hums to self

____ Stimming activity / hand flapping

Please provide any additional concerns or information that you feel may be important regarding your child:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Printed name of person completing form: _____

Signature of person completing form: _____

Date Completed: _____

ALLERGY NOTIFICAITON

From time to time your child's therapist may utilize examination gloves and various foods in the course of therapy to assess or stimulate certain speech-related behaviors. We are aware of the fact that some children are allergic to the materials used in examination gloves and may be on specialized diets or have food allergies. Please read the following lists carefully and indicate any allergies you know your child has. Please list any other known allergies in the space below. This information will be noted in a prominent place on your child's chart. Please keep your child's therapist informed of any allergic reaction, which are identified in your child over the course of his/her therapy program. Your child's health and safety are of the utmost importance to us.

The following are some of the foods and substances commonly used in therapy. Please circle any that your child is allergic to OR any which are not a part of your child's special diet:

Talc (powder)	latex
Chewy sweet tarts	chips (Lays, Doritos, Fritos)
Pretzels	Chocolate M&M's
Starburst	gummy worms
Hot tamales	Skittles
Juice	applesauce
Powder sugar (very small amounts)	pixie sticks
Dried cereal (Cheerios, Fruit loops)	hard candy (lollipops)

Please list ANY other known allergies: _____

_____

If your child has no known allergies, please write "NO KNOWN ALLERGIES" in the blank below before signing this form:

_____

I have provided the information above to the best of my knowledge at the request of Little Works in Progress and my child's therapist of any change in the status of the above information.

Child's Name: _____

Responsible Party: _____

Today's Date: _____

AUTHORIZED PERSON(S)

Child's Name: _____ DOB: _____

As the parent/guardian of the child listed above, I authorize discussions regarding therapy sessions, progress, treatment plans and scheduling for my child to be held: (Please Initial One)

_____ In the lobby _____ In a therapy room or private location only

As the parent/guardian of the child listed above, I hereby authorize the Representatives at Little Works in Progress Pediatric Therapy to discuss any information regarding therapy sessions, progress, treatment plans and scheduling of my child with the following person(s). I hereby further authorize the following person(s) to pick up my child from his/her scheduled appointments with Little Works in Progress Pediatric Therapy.

AUTHORIZED PERSON(S)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

CANCELLATION, NO SHOW, LATE PICK-UP POLICY

All sessions are by appointment only and scheduled with a specific tutor. It is the patient's responsibility to attend all scheduled appointments.

Should an appointment need to be cancelled, a 24-hour notification is appreciated whenever possible. All cancellations MUST be made by 9:00 a.m. the day of your child's therapy session to the front desk at (318) 795-3388 for Shreveport and 337-239-3334 for Leesville or the appointment will be considered a NO-SHOW.

Please note that texting or utilization of any social media to notify staff of Little Works in Progress is not considered a formal cancellation. The front desk MUST be notified

If prior notification is not received in a timely manner as stated above, a NO-SHOW fee will be billed to the responsible party. These fees CANNOT be billed to the insurance provider and are due at the time of the next scheduled appointment. Failure to pay NO-SHOW fees will result in your child being removed from the schedule.

The No Show Fee is $35.00 per missed appointment.

If a break in therapy lasting longer than 2 weeks occurs, your child will be removed from the schedule, unless prior arrangements have been made. It is the parent's responsibility to make necessary arrangements and to notify the office of any scheduling conflicts.

If 75% or more scheduled therapy sessions are not kept within each calendar month, your child will be removed from the schedule.

If 2 or more No Shows occur within a calendar month, your child will be removed from the schedule.

Therapy sessions are scheduled back to back. This makes timeliness at the start and end of each session very important. The parent or authorized person responsible for picking the child up at the end of his/her session should be in the lobby 5 minutes prior to the scheduled end time. The Responsible Party will be billed a Late Pick Up Fee of $5.00 per minute for every minute after the session's scheduled end time that the child is not picked up. Late Pick Up Fees CANNOT be billed to the insurance provider and are due at the time of the next scheduled appointment. Failure to pay Late Pick Up Fees will result in your child being removed from the schedule.

By my signature below, I acknowledge that I have read the terms outlined in the Cancellation, No Show, and Late Pick-Up Policy, and agree to honor the terms of this policy.

Child's Name: _____ DOB: _____

Responsible Party Signature: _____

Responsible Party Printed Name: _____

Date Signed: _____

INSURANCE/CREDIT POLICY

Charges for services at our office are due and payable at the time services are rendered. In the event other arrangements are made, a statement will be mailed to you with payment due upon receipt. The client is responsible for payment regardless of the status of insurance claims.

When insurance claims go over 30 days without payment, the client must either suspend therapy until claims are paid to current status or continue therapy on a cash basis at the time services are provided. If the insurance company reimburses for claims already paid by the client, a refund check will be promptly issued to the client. Once all claims are paid to 30 days or less, the client will no longer be required to make cash payments, other than customary co-pays and deductibles, at the time of therapy.

Except when hardship warrants otherwise, accounts 90 days past due are referred for collection. If you are involved in a liability claim, the above stated policies apply. We are unable to wait for settlement by the involved parties.

Little Works in Progress accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department. It is the responsibility of the patient to inform our office of any changes in insurance coverage at the time of the change. Failure to do so could cause delay or denial of insurance payment and/or the patient being assigned responsibility for said charges. Patients are responsible for co-payments and deductibles at time of service. If applicable, you will be billed for services not covered by your insurance by our billing department.

I have read and understand the above stated credit policy. I authorize Wardell Interests, Inc. aka Little Works in Progress Pediatrics Therapy to bill my insurance provider on my or my dependent's behalf. I accept ultimate responsibility for my account and the amount due for services rendered. I will do everything possible to assist in collecting from my insurance carrier, if applicable.

_____ _____

CHILD'S NAME D.O.B.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

_____

RESPONSIBLE PARTY PRINTED NAME

CONSENT FOR SECURE/RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____

I/WE hereby authorize and request Little Works in Progress to secure and /or release medical, social, educational, and other clinical information regarding the patient named above. I/WE understand that this authorization maybe revoked in writing at any time. Otherwise this consent automatically expires two years from the date of signature. This authorization applies only to the following individuals/institutions: If not completed, no information will be released from our office.

Primary Care Physician: _____

Address: _____

Other: _____

Address: _____

I/We give permission for the therapist and or staff at Little Works in Progress to disclose/request information regarding scheduling of school based appointments, therapy, school performance, and/or any information deemed relevant to academic and therapy success. Information will not be disclosed to anyone not specifically listed below.

School Name: _____

Address: _____

Other: _____

Address: _____

I/We give permission for Little Works in Progress to communicate via email, information, i.e. evaluations, therapy updates, and/or other clinical information regarding the patient listed above. Information will not be disclosed to anyone not specifically listed below.

Email Address: _____

Email Address: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposes authorized herein.

Signature: _____ Date: _____

Relationship (if person named above is a minor): _____

Witness signature: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

I have received a copy of Notice of Privacy Practices; as well as, Patient Rights and Responsibilities.

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Date Signed: _____

AUTHORIZATION FOR AUTOMATIC HEALTH CARE PAYMENT BY CREDIT CARD

I authorize Little Works in Progress Pediatric Therapy to keep my signature on file and to charge my account for charges that are deemed Patient Responsibility.

This authorization extends to all recurring charges, co-payments, or deductibles incurred at the time of service unless another method of payment is provided at the time of service.

This authorization also applies to any missed appointments as described in the cancellation and No- Show Policy. If the applicable fee cannot be paid by other means at the next scheduled appointment, your credit card on file will be charged the appropriate amount per stated policy.

This authorization shall be valid for one year, or until services are concluded, or with written notice to Little Works in Progress Pediatric Therapy.

Patient's Name: _____

Cardholder's Name: _____

Cardholder's Billing Address: _____

_____

Credit Card Account Number: _____

3-Digit CVC (back of card): _____

Expiration Date: _____

Signature of Cardholder: _____

Date Signed: _____

Please note: Any charges that are declined will result in a $25.00 fee for reprocessing. Cards whose expiration dates occur during the course of the year will be subject to the above fees, if not updated within 10 days of notification of expiration.

LITTLE WORKS IN PROGRESS PEDIATRIC THERAPY PATIENT SATISFACTION SURVEY

Informed Consent

Little Works in Progress Pediatric Therapy has retained CGI Communications, Inc. to gather feedback for the purpose of improving our services and processes to benefit our clients. To obtain this valuable information CGI plans to email and/or text a satisfaction rating survey from those individuals or businesses that have used our services in the past.

Your signature below will indicate your voluntary consent to participate in the survey. Your contact information will be kept confidential.

Little Works in Progress Pediatric Therapy values your feedback and always strives to serve you better.

Your Name: _____

Cell Phone Number: _____

Email Address: _____

Business Name (If applicable)***:*** _____

Statement of Consent: I have read the above information and hereby consent to take part in the survey. I also give my permission to tape-record my survey interview.

Your Signature: _____ Date: _____

CGI Communications, Inc.
130 East Main St, Granite Building, 8th Floor, Rochester, NY 14604
800-398-3029

****Please keep for your records****

NOTICE OF PRIVACY RIGHTS

How Your Health Information May Be Used:

To Provide Treatment

We will use your health information within our office to provide you with the best services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between speech language pathologists, occupational therapist, physical therapist, and business office staff. In addition, we may share your health information with physicians, referring health care professionals, and other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive or it may be included with an insurance form filed for you in the mail or sent electronically. We will work only with companies who share our commitment to the security of your health information, meaning they are compliant with HIPAA regulations.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Health information may be included in peer review for our employees and associates. It is also possible that insurance companies or government appointed agencies, as part of their quality assurance and compliance reviews will disclose health information during audits. Your health information may be reviews during the routine processes of certification, licensing, or credentialing activities.

As Patient Reminders

Because consistency is very important in your therapy, we may remind you of scheduled appointments or evaluations. We believe in consistency of care and will inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care we can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you inform our office that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment, or medical device.

****Please keep for your records****

NOTICE OF PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain used and disclosures of your health information. Our office will make every effort to honor reasonable restriction request from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately, with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information records in question were not created by our office, are not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our facility for any reason other than for treatment, payment, or health operations. Please let us know in writing the time period of which you are inquiring. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail, or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this notice. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised notice.

You have the right to express complaints to us or the secretary of Health and Human Services if you believe your rights have been compromised. We encourage you to express any concern you have regarding the privacy of your information. Please let us know your concerns or complaints in writing.

****Please keep for your records****

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

Summary of Patient Rights:

The right to considerate, confidential, private, and respectful care.

The right to understand information about your diagnosis and possible treatments.

The right to know the name, role, and credentials of the people treating you.

The right to privacy of treatment records unless you have given permission to release information.

The right to review your treatment records and to have the information explained.

The right to know if Little Works in Progress has relationships with outside parties that may influence your care.

The right to give consent or decline any part of treatment. If you choose not to take part, you will receive the most effective care Little Works in Progress provides.

The right to know about our office policy that affects you and your treatment.

The right to an itemized bill of charges and payments.

The right to know about and have access to office resources, such as directors, administrators, and coordinators, that can help you resolve problems and questions about your office visit and care.

The right to a quick response from our administrative team regarding any comments, questions, or complaints.

Summary of Patient Responsibilities:

The responsibility to be prompt for all scheduled appointments.

The responsibility of notifying the office 24 hours in advance of cancellation

The responsibility of providing any information regarding previous evaluations, or health issues such as allergies or special diets.

The responsibility of providing Little Works in Progress with correct and/or updated information regarding address, telephone, change of custody status, insurance coverage (Insurance card).

The responsibility of asking questions when you do not understand instructions or information.

The responsibility to notify your therapist if you are unable or unwilling to follow therapy recommendations.

The responsibility of being considerate of the needs of other patients and staff.

The responsibility to assure appropriate behavior of all non-patient visitors brought to our office.

The responsibility to pay copayments or fees for services received at the time of treatment.

The responsibility to meet with the business office if payment arrangements need to be made due to unforeseen circumstances.

The responsibility to know and confirm benefits prior to receiving treatment.

The responsibility to verify that Little Works in Progress is/is not providing services within the network of your insurance coverage.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

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 M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

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

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.