



Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, MI)			2. Patient's birthdate/sex MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			3. Insured's ID # (include all letters and numbers)				
4. Patient's address (number, street)			5. Patient's Relation to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			6. Insured's Name (Last, First, MI)				
City		State	7. Was condition related to: a. Patient's employment Y <input type="checkbox"/> N <input type="checkbox"/> b. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/>			8. Insured's address (number, street)				
Zip Code		Phone (Area Code)		City		State				
9. Other insured's name (Last, First, MI)			a. Other insured's Plan name			Zip Code		Phone (Area Code)		
Other insured's Plan address (number, street)			b. Other insured's policy number			10. Insured's group # (or group name)				
City		State	Zip Code	Phone (Area Code)		12. I authorize payment of medical benefits to undersigned physician or supplier for services described below. <i>Signed (insured or authorized person)</i>				
11. 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. <i>Signed</i> _____ <i>Date</i> _____										
13. Date of current: MM DD YY			14. If emergency, check here <input type="checkbox"/>			15. First date patient had same or similar illness MM DD YY				
16. Name of referring provider or other source			16a. _____ 16b. NPI			17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY				
18. Outside lab? Yes <input type="checkbox"/> No <input type="checkbox"/>		\$ Charges		19. Prior authorization number		20. Hospitalization dates related to current services From MM DD YY To MM DD YY				
21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line) 1. _____ 2. _____ 3. _____ 4. _____										
22. A. Date(s) of service From MM DD YY To MM DD YY		B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS Modifier		D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering DHS Provider Number
										DMAP: _____ NPI: _____
										DMAP: _____ NPI: _____
										DMAP: _____ NPI: _____
										DMAP: _____ NPI: _____
										DMAP: _____ NPI: _____
										DMAP: _____ NPI: _____
										DMAP: _____ NPI: _____
23. Federal tax ID #			SSN EIN <input type="checkbox"/> <input type="checkbox"/>			24. Total charge		25. Total Medicare payment		
26. Patient's account #			27. Accept assignment? Y <input type="checkbox"/> N <input type="checkbox"/>			28. Ins (not Medicaid/Medicare)		29. Balance due		
30. Service facility location information						31. Billing provider information and phone number				
NPI #:			DMAP #:			NPI #:		DMAP #:		