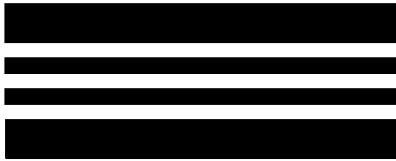




MEDICAL MUTUAL



Submit claim to Medical Mutual using the address on the member's ID card.

VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION										
1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)			2. PATIENT'S DATE OF BIRTH			3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)				
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>			6. SUBSCRIBER'S IDENTIFICATION NO.				
			7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>			8. SUBSCRIBER'S GROUP NO. RECIPROcity ← N →				
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.)			10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>			11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)				
						11A. CHAMPUS SPONSOR'S STATUS <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED BRANCH OF SERVICE				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED _____ DATE _____										
PHYSICIAN OR SUPPLIER INFORMATION										
14. DATE OF:		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES		16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>		
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____			DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____					
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)					20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____					
21. NUMBER AND NAME OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE) [] [] [] [] []					22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES					
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3 ETC. OR DX CODE						B. EPSDT YES <input type="checkbox"/> NO <input type="checkbox"/> FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO.				
24. A DATE OF SERVICE FROM TO		B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)			D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G T.O.S	H M
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PARTY THEREOF)			26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES <input type="checkbox"/> NO <input type="checkbox"/>			27. TOTAL CHARGE		28. AMOUNT PAID	29. BALANCE DUE	
			30. YOUR SOCIAL SECURITY NO.			31. PHYSICIAN, SUPPLIER AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.				
32. YOUR PATIENT'S ACCOUNT NO.			33. YOUR EMPLOYER ID NO.							

Signature of Physician (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PLACE OF SERVICE CODES:


- 1 – Inpatient Hospital
- 2 – Outpatient Hospital
- 3 – Doctor's Office
- 4 – Patient's Home
- 5 – Day Care Facility (PSY)
- 6 – Night Care Facility (PSY)
- 7 – Nursing Home
- 8 – Skilled Nursing Facility
- 9 – Ambulance
- 0 – Other Locations
- A – Independent Laboratory
- B – Ambulatory Surgical Center

- C – Residential Treatment Center
- D – Specialized Treatment Facility
- E – Comprehensive Outpatient Rehabilitation Facility
- F – Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 – Medical Care
- 2 – Surgery
- 3 – Consultation (Inpatient only)
- 4 – Diagnostic X-Ray
- 5 – Diagnostic Laboratory
- 6 – Radiation Therapy

- 7 – Anesthesia
- 8 – Assistant at Surgery
- 9 – Other Medical Service
- 0 – Blood or Packed Red Cells
- A – Used DME
- F – Ambulatory Surgical Center
- H – Hospice
- L – Renal Supplies in the Home
- M – Alternate Payment for Maintenance Dialysis
- N – Kidney Donor
- V – Pneumococcal Vaccine
- Y – Second Opinion on Elective Surgery
- Z – Third Opinion on Elective Surgery



DOE, JOHN
Subscriber Name

123456789
Identification Number

123ABC
Group Number

F 19 4.00/1.00 D 034 12-31-92
Rx TypeChd AgeDed AmtAg CdDays SupplyExp Date



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