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 NPI: 9768450132

2b. Billing Provider Taxonomy: 123X00000X

3. Provider Name: Smith, Joe

4. Eligibility Date (MM/DD/CCYY): 01/02/2021

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) Black (2) AmIndian/AlaskNat (4)
Asian (5) Unk/Not Rep (6) 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: K

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. Provider 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. Z30430 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	01	02	2021	01	02	2021	1	4	74000		1	1	$22 91	Perf Prov Taxonomy / Perf Prov NPI
2														Perf Prov Taxonomy / Perf Prov NPI
3														Perf Prov Taxonomy / Perf Prov NPI
4														Perf Prov Taxonomy / Perf Prov NPI
5														Perf Prov Taxonomy / Perf Prov NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed $

36. **Total Charges** $22.91

37. Signature of Physician or Supplier
Date: 01/02/2021
Signed: Jenny 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 + 4 Code & Phone No.
Jenny Smith
1234 Oak Drive
Houston, Texas 77485-1234