

<b>2017 Claim Form</b>		1. Choose one: <input type="checkbox"/> Family Planning Program: XIX <input type="checkbox"/> DSHS Family Planning Program (DFPP)				1a. DFPP only: <input type="checkbox"/> Partial Pay <input type="checkbox"/> 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 <input checked="" type="checkbox"/> F <input type="checkbox"/> M		11. Patient Status <input checked="" type="checkbox"/> New Patient <input type="checkbox"/> Established Patient		12. Patient's Social Security Number 123 - 456 - 7089		
13. Race (Code No.): White (1) Black (2) AmIndian/AlaskNat (4) Asian (5) Unk/Not Rep (6) NatHawaii/PacIsland (7) More than one race (8)			13a. Ethnicity: Hispanic (5) Non-Hispanic (0)			14. Marital Status: (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		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		
20. Primary Birth Control Method at End of this Visit		A						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? <input type="checkbox"/> Y (If Y, Complete Items 23-25a.) <input type="checkbox"/> 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			28. Level of Practitioner				
			27b. Referring NPI			<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Mid-Level <input type="checkbox"/> Other				
29. Diagnosis Code (Relate A-L to service line 32E) A. Z3009 B. C. D. E. F. G. H. I. J. K. L.						ICD Ind. 0		30. Authorization Number		
								31. Date of Occurrence (MM/DD/CCYY)		
32. A		B		C		D		E		
F		G		H		I		J		
K		L		M		N		O		
P		Q		R		S		T		
U		V		W		X		Y		
Z		AA		AB		AC		AD		
AE		AF		AG		AH		AI		
AJ		AK		AL		AM		AN		
AO		AP		AQ		AR		AS		
AT		AU		AV		AW		AX		
AY		AZ		BA		BB		BC		
BD		BE		BF		BG		BH		
BI		BJ		BK		BL		BM		
BN		BO		BP		BQ		BR		
BS		BT		BU		BV		BW		
BX		BY		BZ		CA		CB		
CC		CD		CE		CF		CG		
CH		CI		CJ		CK		CL		
CM		CN		CO		CP		CQ		
CR		CS		CT		CU		CV		
CW		CX		CY		CZ		DA		
DB		DC		DD		DE		DF		
DG		DH		DI		DJ		DK		
DL		DM		DN		DO		DP		
DQ		DR		DS		DT		DU		
DV		DW		DX		DY		DZ		
EA		EB		EC		ED		EE		
EF		EG		EH		EI		EJ		
EK		EL		EM		EN		EO		
EP		EQ		ER		ES		ET		
EU		EV		EW		EX		EY		
EZ		FA		FB		FC		FD		
FE		FF		FG		FH		FI		
FJ		FK		FL		FM		FN		
FO		FP		FQ		FR		FS		
FT		FU		FV		FW		FX		
FY		FZ		GA		GB		GC		
GD		GE		GF		GG		GH		
GI		GJ		GK		GL		GM		
GN		GO		GP		GQ		GR		
GS		GT		GU		GV		GW		
GX		GY		GZ		HA		HB		
HC		HD		HE		HF		HG		
HH		HI		HJ		HK		HL		
HM		HN		HO		HP		HQ		
HR		HS		HT		HU		HV		
HW		HX		HY		HZ		IA		
IB		IC		ID		IE		IF		
IG		IH		II		IJ		IK		
IL		IM		IN		IO		IP		
IQ		IR		IS		IT		IU		
IV		IW		IX		IY		IZ		
JA		JB		JC		JD		JE		
JF		JG		JH		JI		JJ		
JK		JL		JM		JN		JO		
JP		JQ		JR		JS		JT		
JU		JV		JW		JX		JY		
JZ		KA		KB		KC		KD		
KE		KF		KG		KH		KI		
KJ		KK		KL		KM		KN		
KO		KP		KQ		KR		KS		
KT		KU		KV		KW		KX		
KY		KZ		LA		LB		LC		
LD		LE		LF		LG		LH		
LI		LJ		LK		LL		LM		
LN		LO		LP		LQ		LR		
LS		LT		LU		LV		LW		
LX		LY		LZ		MA		MB		
MC		MD		ME		MF		MG		
MH		MI		MJ		MK		ML		
MN		MO		MP		MQ		MR		
MS		MT		MU		MV		MW		
MX		MY		MZ		NA		NB		
NC		ND		NE		NF		NG		
NH		NI		NJ		NK		NL		
NO		NP		NQ		NR		NS		
NT		NU		NV		NW		NX		
NY		NZ		OA		OB		OC		
OD		OE		OF		OG		OH		
OI		OJ		OK		OL		OM		
ON		OO		OP		OQ		OR		
OS		OT		OU		OV		OW		
OX		OY		OZ		PA		PB		
PC		PD		PE		PF		PG		
PH		PI		PJ		PK		PL		
PM		PN		PO		PP		PQ		
PR		PS		PT		PU		PV		
PW		PX		PY		PZ		QA		
QB		QC		QD		QE		QF		
QG		QH		QI		QJ		QK		
QL		QM		QN		QO		QP		
QQ		QR		QS		QT		QU		
QV		QW		QX		QY		QZ		
RA		RB		RC		RD		RE		
RF		RG		RH		RI		RJ		
RK		RL		RM		RN		RO		
RP		RQ		RR		RS		RT		
RU		RV		RW		RX		RY		
RZ		SA		SB		SC		SD		
SE		SF		SG		SH		SI		
SJ		SK		SL		SM		SN		
SO		SP		SQ		SR		SS		
ST		SU		SV		SW		SX		
SY		SZ		TA		TB		TC		
TD		TE		TF		TG		TH		
TI		TJ		TK		TL		TM		
TN		TO		TP		TQ		TR		
TS		TT		TU		TV		TW		
TX		TY		TZ		UA		UB		
UC		UD		UE		UF		UG		
UH		UI		UJ		UK		UL		
UM		UN		UO		UP		UQ		
UR		US		UT		UU		UV		
UW		UX		UY		UZ		VA		
VB		VC		VD		VE		VF		
VG		VH		VI		VJ		VK		
VL		VM		VN		VO		VP		
VQ		VR		VS		VT		VU		
VV		VW		VX		VY		VZ		
WA		WB		WC		WD		WE		
WF		WG		WH		WI		WJ		
WK		WL		WM		WN		WO		
WP		WQ		WR		WS		WT		
WU		WV		WW		WX		WY		
WZ		XA		XB		XC		XD		
XE		XF		XG		XH		XI		
XJ		XK		XL		XM		XN		
XO		XP		XQ		XR		XS		
XT		XU		XV		XW		XZ		
YA		YB		YC		YD		YE		
YF		YG		YH		YI		YJ		
YK		YL		YM		YN		YO		
YP		YQ		YR		YS		YT		
YU		YV		YW		YX		YZ		
ZA		ZB		ZC		ZD		ZE		
ZF		ZG		ZH		ZI		ZJ		
ZK		ZL		ZM		ZN		ZO		
ZP		ZQ		ZR		ZS		ZT		
ZU		ZV		ZW		ZX		ZY		
ZZ										