HMO Louisiana

# HEALTH INSURANCE CLAIM FORM

**READ INSTRUCTIONS ON BACK BEFORE COMPLETING OR SIGNING THIS FORM**

**MAIL COMPLETED CLAIMS TO:**

HMO LOUISIANA, INC.
CLAIMS PROCESSING
P.O. BOX 98024
BATON ROUGE, LA 70898-9024

## PATIENT AND INSURED (SUBSCRIBER) INFORMATION

***PLEASE PRINT OR TYPE*** — **ONLY ONE PATIENT PER CLAIM FORM**

1. SUBSCRIBER'S HMO LOUISIANA, INC. CONTRACT NO.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M ☐ F ☐

4. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

5. PATIENT'S ADDRESS (No. Street)

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

7. SUBSCRIBER'S ADDRESS (STREET NO.)

CITY | STATE

8. IS THERE ANOTHER HEALTH BENEFIT PLAN?
☐ YES ☐ NO
IF YES, COMPLETE ITEM 9.

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO
a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
b. AUTO ACCIDENT? ☐ YES ☐ NO
c. OTHER ACCIDENT OR INJURY ☐ YES ☐ NO
d. DATE OF ACCIDENT OR INJURY?

ZIP CODE | TELEPHONE (Include Area Code) ( )

☐ CHECK IF THIS IS A NEW ADDRESS

a. OTHER INSURED'S POLICY OR GROUP NUMBER

11. SUBSCRIBER'S POLICY GROUP NO. OR GROUP NAME

b. OTHER HEALTH INSURANCE COVERAGE NAME AND ADDRESS

a. SUBSCRIBER'S DATE OF BIRTH MM DD YY

b. SUBSCRIBER'S SEX M ☐ F ☐ — RETIRED ? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**

**12. FOR OFFICE USE ONLY**

**13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.**

X
SIGNED (PATIENT OR AUTHORIZED PERSON)

## PHYSICIAN OR SUPPLIER INFORMATION (ONLY ONE PHYSICIAN PER CLAIM FORM)

14. DATE OF CURRENT MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 20E BY LINE)
1. 3.
2. 4.

| 20. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B.* Place of Service | C.* Type of Service | D. PROCEDURES, SERVICES OR SUPPLIES CPT HCPCS | MODIFIER | E. DIAGNOSIS CODE | F. $ CHARGES | G. DAYS OR UNITS | H. EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES |
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21. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

22. PATIENT'S ACCOUNT NO.

23. TOTAL CHARGE $

24. AMOUNT PAID $

25. BALANCE DUE $

26. 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

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

29. PHYSICIAN'S/SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN # GRP #

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON BACK REMARKS

## HOW TO FILE A CLAIM

**Items 1 through 12 of the top portion of the claim form must be filled out by you. The doctor, hospital or supplier may complete the bottom portion of the form; or you may attach a copy of an itemized bill of the charges from the doctor or supplier. A sample of the part that you must complete is shown below.**

### PATIENT AND INSURED (SUBSCRIBER) INFORMATION



| *PLEASE PRINT OR TYPE* — ONLY ONE PATIENT PER CLAIM FORM | | |
|---|---|---|
| | | 1. SUBSCRIBER'S HMO LOUISIANA, INC. CONTRACT NO. |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM \| DD \| YY SEX M ☐ F ☐ | 4. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) |
| 5. PATIENT'S ADDRESS (No. Street) | 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ | 7. SUBSCRIBER'S ADDRESS (STREET NO.) |
| CITY / STATE | 8. IS THERE ANOTHER HEALTH BENEFIT PLAN? | CITY / STATE |
| ZIP CODE / TELEPHONE (Include Area Code) ( ) | ☐ YES ☐ NO IF YES, COMPLETE ITEM 9. | ZIP CODE / TELEPHONE (Include Area Code) ( ) ☐ CHECK IF THIS IS A NEW ADDRESS |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO | 11. SUBSCRIBER'S POLICY GROUP NO. OR GROUP NAME |
| b. OTHER HEALTH INSURANCE COVERAGE NAME AND ADDRESS | b. AUTO ACCIDENT? ☐ YES ☐ NO | a. SUBSCRIBER'S DATE OF BIRTH MM \| DD \| YY |
| | c. OTHER ACCIDENT OR INJURY ☐ YES ☐ NO | b. SUBSCRIBER'S SEX M ☐ F ☐ RETIRED ? ☐ YES ☐ NO |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | d. DATE OF ACCIDENT OR INJURY? | c. INSURANCE PLAN NAME OR PROGRAM NAME |

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**

| 12. FOR OFFICE USE ONLY | 13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. |
|---|---|
| | X _____ SIGNED (PATIENT OR AUTHORIZED PERSON) |

## INSTRUCTIONS

1. **Subscriber's HMO Louisiana, Inc. Contract Number -** Please fill in the insured's contract number exactly as shown on the insured's Blue Cross and Blue Shield identification card. You should double check this number to be sure it is correct.
2. **Patient's Name -** Please fill in the patient's name as it appears on the insured's HMO Louisiana, Inc. application.
3. **Patient's Birth Date -** Please enter month, day, year and check male or female. For example: May 21, 1958 would be 5/21/58.
4. **Subscriber's Name -** Please fill in the insured's name as it appears on the HMO Louisiana, Inc. identification card.
5. **Patient's Address -** Please fill in the patient's complete mailing address and correct telephone number.
6. **Patient's Relationship to Insured -** Please check the block that indicates how the patient is related to the insured.
7. **Subscriber's Address -** Please enter the complete mailing address and telephone number of the HMO Louisiana, Inc. policyholder. If this information was already entered in item 5, then you may enter "same." If this is a new address, please check the block provided.
8. **Is there another Health Benefit Plan? -** If the patient is covered by another group health policy, check the "yes" block and answer item 9.
9. **Other Insured's -** If the patient is covered by another group health policy through an employer or by Medicare, please fill in the policyholder's name.
   a. Other Insured's Policy or Group Number - Please enter the policy number used by the other insurance coverage.
   b. Other Health Insurance Coverage Name and Address - Please enter the name and address used by the other insurance company.
   c. Insurance Plan Name - Please enter the plan or program name used by the other insurance company.
10. **Is Patient's Condition Related To -**
    a. Employment (Current or Previous ) - Check yes or no.
    b. Auto Accident - Check yes or no.
    c. Other Accident or Injury - Check yes or no.
    d. Date of Accident or Injury - If a "yes" block was checked in item 10, please indicate the date. Please enter month, day, year.
11. **Subscriber's Policy Group Number or Group Name -** Please enter the Group number as shown on the insured's HMO Louisiana, Inc. identification card. If this information is not available, please enter the name of the company that employs the insured.
    a. Subscriber's Date of Birth - Please enter month, day, year. For example: September 15, 1956 would be 9/15/56.
    b. Subscriber's Sex - Please indicate whether the insured is male or female and if that person is retired.
    c. Insurance Plan Name - Please enter the plan name or program name.

### PLEASE NOTE

Blocks 1 thru 12 of this form MUST be completed. If blocks 14-29 are not completed, the doctor's statement of services rendered MUST be attached to this claim form. If the attending doctor's statement is attached, the doctor's signature is not required in block 26 of this claim form. Please submit only one patient per claim form and only one physician per claim form.

## FOR PHYSICIAN/SUPPLIER USE ONLY

**PLACE OF SERVICE CODES**

1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - (ASC) - Ambulatory Surgical Center
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Center
E - (COR) - Comprehensive Outpatient Rehabilitation Facility
F - (KDC) - Independent Kidney Disease Treatment Center

**TYPE OF SERVICE CODES**

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Services
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