This claim form is used when an employee goes to an out of network provider for medical services.

Fill in lines 1-13 on the claim form. If you want the payment to be issued to the physician, sign line 13. Line 1a is to be filled in with the employee’s medical ID number.

Mail the completed claim form with an itemized bill (showing the date of service, diagnosis, service(s) provided, doctor’s name and address), to CoreSource/HealthLink PO Box 419104 St. Louis, MO 63141-9104.
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFFERS TO GOVERNMENT PROGRAMS ONLY

MEDIcare AND CHAMPUS PENDMENTS: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient’s signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status and whether the person has employer group health insurance, liability, no-fault, worker’s compensation or other insurance which is responsible for paying for the services for which the Medicare claim is made. See 42 CFR 411.24(a), if item 9 is completed, the patient’s signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS cases, the physician chooses to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charges determined by the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient’s sponsor should be provided in those items captioned in “Insured,” i.e., item 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnostic coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDIcare, CHAMPUS, FEca AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as “incident” to a physician’s professional service, 1) they must be rendered under the physician’s immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician’s service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of nonphysicians must be included on the physician’s bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contact employee of the United States Government, either civilian or military (refer to 5 USC 6556). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 402.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDIcare, CHAMPUS, FEca AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1882, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.6(a) (8), and 44 USC 12101(a) and 10 USC 1079 and 1081; 5 USC 8101 et seq and 50 USC 901 et seq; 39 USC 613; E.O. 12937.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties pay to primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine use for information contained in systems of records.


FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE: To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USES: Information from claims and related documents may be given to the Dep’t of Veterans Affairs, the Dept. of Health and Human Services and/or the Dep’t of Defense consistent with written statutory authorities under CHAMPUS/CHAMPVA; to the Dep’t of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment actions; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual/patient of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDIcaid PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX plan and to furnish Information regarding any payments claimed for providing such services as the State Agency or Dep’t of Health and Human Services may request.

I further agree, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN OR SUPPLIER: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal supervision, including any information necessary to determine the amount charged.

NOTICE: This is to certify that the foregoing Information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including times for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or another aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 28844, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0058), Washington, D.C. 20503.