# APWU HEALTH PLAN

**Please refer to member ID for correct mailing address to submit completed claim.**

**PATIENT AND INSURED INFORMATION**

| | | |
|---|---|---|
| 1 MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐ | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ | 7. INSURED'S ADDRESS (No., Street) |
| CITY / STATE | 8. PATIENT STATUS Single ☐ Married ☐ Other ☐ | CITY / STATE |
| ZIP CODE / TELEPHONE (Include Area Code) | Employed ☐ Full-Time Student ☐ Part-Time Student ☐ | ZIP CODE / TELEPHONE (Include Area Code) ( ) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ | b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? ☐ YES ☐ NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d. |
| **READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.** 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ |

**PHYSICIAN OR SUPPLIER INFORMATION**

| | | |
|---|---|---|
| 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. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. / 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. ____ 3. ____ 2. ____ 4. ____ | | 22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER |

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | NPI | |
| 2 | | | | | | | | NPI | |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

| | | | | |
|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐ | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. BALANCE DUE $ |
| 31. 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 | 32. SERVICE FACILITY LOCATION INFORMATION a. b. | | 33. BILLING PROVIDER INFO & PH # ( ) a. b. | | |

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

## FEHB PROGRAM PAYMENTS

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 Blocks 1 through 11d is true, accurate and complete. The patient's signature authorizes any entity to release to Carrier medical and non-medical information, including employment status, and whether the person has other group health insurance, liability, no-fault, worker's compensation, or other insurance which is responsible to pay for the services to which the FEHB claim is made. If item 12 is completed, the patient's signature authorizes release of the information to the health plan or agency shown.

## SIGNATURE OF PHYSICIAN OR SUPPLIER

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 FEHB 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 non-physicians must be included on the physician's bills.
NOTICE: Anyone 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.

## CLAIMS FILING INSTRUCTIONS

To the patient

1. Please fill out the top half of this form. If you want your APWU Health Plan to pay your physician or other professional provider directly, you need to sign and date the "Insured's or Authorized Person's Signature" Section of this form (See item 13). Do NOT sign here if you want to receive payment yourself.
2. You must attach an itemized bill. Cancelled checks, cash register receipts or balance due statements are not acceptable. Please keep a copy of all claims and itemized bills before submitting to your APWU Health Plan.
3. If you are covered by Medicare, No-Fault or other group health insurance, you must attach a payment or denial statement from that carrier with this claim. Otherwise, your claim will be rejected for resubmission with this information.
4. Claims must be submitted by December 31 of the year after the year you received the service. Failure to file within this limit will invalidate your claim.

## PRECERTIFICATION INFORMATION

See Plan's Brochure and Member ID Card for more precertification information.
*Note: Precertification vendors and phone numbers may change each calendar year. The Member ID Card should always be consulted for the latest precertification information and phone numbers.*

**Who is Required to Obtain Precertification**

Members and patients with inpatient admissions to hospitals in the United States who do not have Medicare Part A or other group coverage as their primary carrier. *Failure to have admissions pre-certified will result in a $500 penalty.*
Patients needing certain outpatient radiology services (MRI, CT, PET and MRA). *Failure to secure precertification will result in a $100 penalty.* (Not required where patient has Medicare Part B or other group coverage as their primary carrier.)

**When a Member/Patient Should Precertify**

For elective in-patient admissions, at least 48 hours prior to the scheduled admission.
For emergency admissions, within 48 hours after admission.
For outpatient radiology, any time prior to the service being performed.

**How to Obtain Precertification**

APWU Health Plan members/patients, doctors or hospitals must call directly to initiate precertification for hospital admissions.
Please refer to the APWU HP Member ID card for the phone number to call for in-patient certifications since Vendor information varies based on where the patient lives.
All treatment for Mental Health/Substance Abuse must be authorized through Value Options. Call toll-free 1-888-700-7965.
Outpatient Radiology Services (MRI, CT, PET, MRA) need to be certified by calling toll-free 1-800-582-1314.

**To the Provider**

Please complete the bottom half of the form, items 14-33. Claims submitted without a Federal Tax ID (and valid NPI beginning May 23, 2007) will not be considered.
*Note: Precertification vendors and phone numbers may change each calendar year. The Member ID Card should always be consulted for the latest precertification information and phone numbers.*

**Where to Send Completed Claims**

Please refer to the APWU Health Plan Member ID card for the correct mailing address for paper claims. The Member ID also includes electronic clearinghouse payor information.