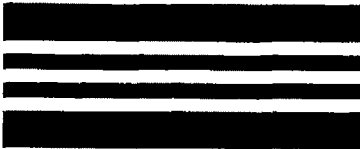


PLEASE
DO NOT
STAPLE
IN THIS
AREA



WASHINGTON STATE HEALTH INSURANCE POOL
FCHN
PO BOX 2289
SEATTLE, WA 98111-2289

CARRIER

HEALTH INSURANCE CLAIM FORM																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					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 M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY STATE																			
ZIP CODE TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					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 BMI210																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
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.										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 _____ DATE _____										SIGNED _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER					24. TABLE																			
A		B		C		D			E		F		G		H		I		J		K								
DATE(S) OF SERVICE From		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE						
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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.)										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #									
SIGNED _____ DATE _____										PIN# _____										GRP# _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

INSTRUCTIONS FOR WSHIP HEALTH INSURANCE CLAIM FORM NON-MEDICARE PLANS

The following fields are mandatory fields. They must be submitted with complete information or the claim cannot be processed.

- 1a. Insured's ID number – This is the number that starts with M210 and is printed on the front of your WSHIP ID card.
2. Patient's Name
3. Patient's Birth Date
5. Patient's Address, City, State and Zip Code
10. If services provided were related to an Auto Accident or Other Accident, please indicate that information. If not related to any type of accident, leave this field blank.
11. Insured's Policy Group - BMI210
- 11c. Insurance Plan Name – WSHIP
- 11d. If you have another health insurance plan in addition to WSHIP, please check "yes". Indicate the name of that insurance plan in 9d and include an explanation of benefits which shows if that plan paid benefits for these services provided for you.
21. Diagnosis of Illness or Injury – This is information that must be provided by the doctor or facility which provided medical services to you. The diagnosis code is at least 3 digits.
- 24a. Dates of Service – this is the date that you received the medical services.
- 24b. Place of Service –
 - 11 – Office
 - 12 – Home
 - 21 – Inpatient Hospital
 - 22 – Outpatient Hospital
 - 23 – Emergency Room – Hospital
 - 53 – Community Mental Health Center
- 24d. Procedure or CPT Code – This is information that must be provided by the doctor or facility which provided medical services to you. The procedure code is a 5 digit code.
- 24e. If the medical procedure for line 1 is a result of diagnosis code 1, then enter a 1 in this field. If it is a result of diagnosis code 1 & 2, then enter 1,2 in the field. If it is a result of diagnosis code 2, then enter 2 in this field.
- 24f. Charges for the medical service provided.
- 24g. Days or Units
25. Federal Tax ID number of the provider.
28. Total Charge – This is the total of all charges entered on this page.
29. Amount Paid – If you have paid for these services, please enter the amount you have paid in this field.
30. Balance Due
31. Signature of physician or licensed person who provided services
32. Name and address of facility where services were received.
33. Physician's or supplier's billing name, address, zip code & phone number.

SUBMIT CLAIMS TO ADDRESS AT THE TOP OF THE CLAIM FORM