



APWU HEALTH PLAN

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTHDATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
5. PATIENT'S ADDRESS (No., Street)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
CITY	STATE	CITY
ZIP CODE	TELEPHONE (Include Area Code) ()	STATE
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE
8. PATIENT STATUS Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		TELEPHONE (INCLUDE AREA CODE) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
10. IS PATIENT'S CONDITION RELATED TO:		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> Yes <input type="checkbox"/> No	b. EMPLOYER'S NAME OR SCHOOL NAME
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No PLACE (State) _____	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	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>
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	

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 _____

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 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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
1. _____	3. _____	23. PRIOR AUTHORIZATION NUMBER	
2. _____	4. _____		

	A			B	C	D		E	F	G	H	I	J	K
	DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	Place of Service	Type of Service			PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE							
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 # _____		

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 nonmedical 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 for 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 nonphysicians must be included on the physician's bills.

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.

HOSPITAL PRECERTIFICATION INFORMATION

Who is Required to Obtain Precertification?

- Effective January 1, 1991, members/patients with inpatient admissions to hospitals in the United States who **do not** have Medicare Part A or other primary insurance coverage, must precertify to avoid a penalty.
- **All** inpatient admissions, including medical/surgical, maternity and psychiatric/chemical dependency, must be precertified to avoid a penalty.
- If certification is not obtained, there will be a \$500 penalty.

When a Member/Patient Should Precertify

- For elective admissions, prior to hospitalization.
- For emergency admissions, within 2 working days following admission.

How APWU Health Plan Members/Patients Obtain Precertification

- APWU Health Plan members/patients, doctors or hospitals must call directly to initiate precertification for hospital admissions. In New Jersey, call Ethix at 1-800-654-1241. In Minnesota, call Preferred One at 1-800-451-9597. For all other areas, call HealthCare COMPARE at 1-800-447-1704.
- If you have questions about eligibility, call APWU Health Plan. The toll-free number is 1-800-222-APWU. Hours of service: 8:30 a.m. to 8:00 p.m. Eastern Standard Time.
- For prior approvals for durable medical equipment, physical/occupational therapy and home nursing, call NHS/Care Review at 1-800-558-4353.

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 returned.
4. Claims must be submitted within two years of date of service. Failure to file within this limit will invalidate your claim.

TO THE PROVIDER

Please complete the bottom half of this form, items 14-33. It is especially important to include your Federal tax identification number.

IF THIS INFORMATION IS INCOMPLETE, PAYMENT WILL BE DELAYED.

WHERE TO SEND YOUR CLAIMS

If your doctor or hospital is one of APWU Health Plan's Preferred Providers mail to:

APWU Health Plan
P.O. Box 185
Burtonsville, MD 20866

All others: **APWU Health Plan**
P.O. Box 967
Silver Spring, MD 20910