DISCLOSURE STATEMENT

This is how to use G and Z codes on a CMS 1500 form to indicate a full SDoH screening and referral. All codes submitted must meet medical coding and documentation standards.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
( ) (Medicare#) (X) (Medicaid#) ( ) (ID#/DoD#) ( ) (Member ID#) ( ) (ID#) ( ) (ID#) ( ) (ID#)	A00000000
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Investments, Targete, D	3. PATIENT'S BIRTH DATE MM 03 DD 14 YY 2014 SEX M ( ) F (X)
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Investments, Targeta, D	
5. PATIENT'S ADDRESS (No., Street): 123 Main St	6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child (X) Other ( )
7. INSURED'S ADDRESS (No., Street): 123 Main St	
CITY: Tempe	STATE: AZ
8. RESERVED FOR NUCC USE	CITY: Tempe / STATE: AZ
ZIP CODE: 85281 / TELEPHONE (Include Area Code): ( )	ZIP CODE: 85281 / TELEPHONE (Include Area Code): (480) 000-0000
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: 00001
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ( ) NO (X)	a. INSURED'S DATE OF BIRTH MM 06 DD 28 YY 84 SEX M (X) F ( )
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ( ) NO (X)	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, complete items 9, 9a, and 9d.

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 Signature on file DATE 3/21/24

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 Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. Z00.121 B. Z59.41 C. D. E. F. G. H. I. J. K. L.		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 03 21 24 03 21 24	11		99383			0.00			NPI	
2 03 21 24 03 21 24	11		G9919			0.00			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 (X) NO ( )	28. TOTAL CHARGE $ 0.00	29. AMOUNT PAID $ 0.00	30. Rsvd. for NUCC Use

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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
TIPQIC SIGNED 3/21/24 DATE	TIPQIC Family Care 123 Mill Ave Tempe, AZ, 85281 a. NPI b.	TIP Healthcare 123 3rd St Phoenix, AZ, 85004 a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION