DISCLOSURE STATEMENT

This is how to use G and Z codes on a CMS to indicate a full SDoH screening with a declined 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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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☑ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): A000000000
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Investments, Targete, D	3. PATIENT'S BIRTH DATE MM DD YY: 03 14 2014 SEX M ☐ F ☑
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 ☑ 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) 0000000	
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
a. INSURED'S DATE OF BIRTH MM DD YY: 06 28 1984 SEX M ☐ F ☑	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☑ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☑ NO
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: 3/21/2025

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. A. F41.1 B. Z00.121 C. Z59.41 D. E. F. G. H. I. J. K. L.	22. 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	03	21	25	03	21	25	11		99203			0.00			NPI	123456
2	03	21	25	03	21	25	11		T1016			0.00			NPI	123456
3	03	21	25	03	21	25	11		G9919	V4		0.00			NPI	123456
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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 $ 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.) TIPQIC SIGNED 3/21/2025 DATE	32. SERVICE FACILITY LOCATION INFORMATION TIPQIC Family Care 185 Mill Ave Tempe, AZ, 85281 a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) TIP Healthcare 123 3rd St Tempe, AZ, 85281 a. NPI b.		

Clear Form