



The instructions below shows what information should be filled in to specific blanks on the MDwise Healthy Indiana Plan Health Claim Forms.

Member Name:		Member RID#	
HIP Member Name		00000000000	
PMP Name: Doctor Name			
PMP Phone: Doctor Phone			
Delivery System: Name of Delivery System			
ER Copay: \$25 or 20%			
POWER Account Amt: \$1100			
Rx Bin 610467		Claim Payer ID:MDWIS	
Rx PCN INCAIDPROD		www.MDwise.org	

Member ID Card

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAD <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER		1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE 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. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <small>If yes, return to and complete items 9 a-d.</small>	

Choose Other

Insert Patient's RID Number (line 1a)

UB-04 Form

Insert Patient's RID Number (line 60)

PAYER NAME		HEALTH PLAN ID		CREATION DATE		TOTALS	
INSURED'S NAME		INSURED'S UNIQUE ID		GROUP NAME		INSURANCE GROUP NO.	
TREATMENT AUTHORIZATION CODES		DOCUMENT CONTROL NUMBER		EMPLOYER NAME			

For complete instructions, please visit www.MDwise.org, choose HIP, Provider Relations, Claims. The full instructions are on the Claims page in PDF format for download.



If you have any questions, please call 1-877-822-7196 or 317-822-7196 in the Indianapolis Area.



Highlighted Areas on the Forms Must Be Filled In



HEALTHY INDIANA PLAN™ Health Coverage = Peace of Mind

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE-CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member/ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK/LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <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) ()					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 Not required									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____					c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete items 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.										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: 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 PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17a. _____										17b. NPI _____																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																			
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. _____																													
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. ICD-9-CM Family Reim		I. ID. QUAL.		J. RENDERING PROVIDER ID. #									
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> (For gov. claims, see back)					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE 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 # ()									
SIGNED _____ DATE _____										a. NPI _____ b. _____										a. NPI _____ b. _____									

