



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

PICA		PICA	
1. MEDICARE <input type="checkbox"/> Medicare #		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
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:		11. INSURED'S DATE OF BIRTH	
10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	

Choose Other (line 1a)
Insert Patient's RID Number (line 1a)

UB-04 Form

PAGE OF		CREATION DATE		TOTALS	
50 PAYER NAME	51 HEALTH PLAN ID	52 FEE INFO	53 PRIOR PAYMENTS	54 EST. AMOUNT DUE	55 NPI
58 INSURED'S NAME	59 P-REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	63 OTHER PRV ID
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	

Insert Patient's RID Number (line 60)

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 1-800-356-1204 or 317-630-2831 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 <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
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 BLKLUNG <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) ()					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 Not required																																							
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 SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										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 If yes, return to and complete item 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. SIGNED _____ DATE _____										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 _____																																																	
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 PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										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) 1. _____ 3. _____ 2. _____ 4. _____										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. EPSTD Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																	
1										NPI																																																	
2										NPI																																																	
3										NPI																																																	
4										NPI																																																	
5										NPI																																																	
6										NPI																																																	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. 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.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____																																							

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

