



HEALTH INSURANCE CLAIM FORM

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

CORPORATE MANAGEMENT GROUP-WC
ATTN: WORKERS' COMP COORDINATOR
12000 NORTH WASHINGTON STREET STE 350
DENVER, CO 80241

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) XXXXXX4675																																																																																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GURLEY JR-WC BARRY L										3. PATIENT'S BIRTH DATE 10 07 1997 <input checked="" type="checkbox"/> M <input type="checkbox"/> F					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																														
5. PATIENT'S ADDRESS (No., Street) 376 BLACK SMITH RD										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																																																																																														
CITY DOUGLASSVILLE					STATE PA					8. RESERVED FOR NUCC USE					CITY					STATE																																																																																									
ZIP CODE 19518					TELEPHONE (Include Area Code) (484) 772.0504					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																																																																																									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					10a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					10b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					10d. CLAIM CODES (Designated by NUCC)					11a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					11b. OTHER CLAIM ID (Designated by NUCC) CORPORATE MANAGEMENT GROU					11c. INSURANCE PLAN NAME OR PROGRAM NAME																																																											
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. SIGNATURE ON FILE SIGNED _____ DATE 10.30.2017										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____																																																																																																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 10 30 2017 QUAL. 431										15. OTHER DATE QUA 439 10 30 2017										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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										A. S51.812A										B. _____										C. _____										D. _____										E. _____										F. _____										G. _____										H. _____										I. _____										J. _____									
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #																																																																																		
From MM DD YY To MM DD YY									CPT/HCPCS MODIFIER																																																																																																				
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25. FEDERAL TAX I.D. NUMBER 27-2272976 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 51*60548*1*1										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 257.00										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.) Jennifer A Dwyer, DO SIGNED _____ DATE 11 07 2017										32. SERVICE FACILITY LOCATION INFORMATION PATIENT FIRST POTTSTOWN 119 SHOEMAKER ROAD POTTSTOWN PA 194646429										33. BILLING PROVIDER INFO & PH # 800 447-8588 PATIENT FIRST POTTSTOWN P.O. Box 758952 Baltimore, MD 21275-8952																																																																																									
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CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE 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 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

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.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. **DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.**

PATIENT FIRST - POTTSTOWN

119 SHOEMAKER ROAD

- POTTSTOWN PA 194646429

- 610/427-4919

Medical Record for BARRY L GURLEY JR-WC

MEDICAL RECORD

PATIENT NAME	BIRTHDATE	VISIT DATE	AGE	SEX	COMPLAINT
BARRY L GURLEY JR-WC	10/07/1997	10/30/17	20	M	L Forearm Lac
MED. REC. #	FAMILY MD	IN BY	HST BY	PRINTED DATE-TIME	1st CONSULT
60548*1*1	None	Self	Self	11/07/17 - 04:17	

E&M CODE - New

ALLERGIES- NKA

MEDICINES- None

LAST TETANUS->5

BP-108/60 RmL P-80 R-20 T-98 10:35 eg51

HEIGHT-69 WEIGHT-203 BMI-29.9

SPO2-100% P-74 O2-N 10:35 eg5

OCCUPATION-Machine Operato

REMARKS- Employment Verified by Jamie Ready/Administrative Assitant
HR/303.920.1425/jms Fax#303-736-7767.

HISTORY

HPI w/CC- Chief complaint: Laceration. HPI: Has a 3-hour history of a laceration to the left forearm. Was walking out of work when he cut himself on the edge of a sharp table. Bleeding controlled with direct pressure. Tetanus is up to date. (-LAC)

ROS- No numbness, weakness, paresthesias, active bleeding or discharge. (-LAC)

PHYSICAL- Vitals noted. Alert and oriented in NAD. Musculoskeletal: FROM of upper extremities. Muscle strength 5/5. No bony tenderness. A 3-cm laceration to the dorsal aspect of the left forearm. Is not full thickness. Is fairly well approximated. No active bleeding. (-LAC)

SUPPLIES- Steri-Strips (mm151- 10:45)

INSTRUCTIONS- Laceration BMI-High RS 10.30.17 10:46

PROV COMMENTS- Laceration. Copiously irrigated by staff. Wound closure successful with Steri-Strips. Wound care instructions given. FU prn. Expressed understanding. Left without further questions. (-LAC)

COMMENTS- _10.30.17 Patient signed ROI authorizing release of information to Corporate Management Group (jms51) _10.30.17 11:06 Call placed to Jamie Ready/Administrative Assistant/303.920.1425 to advise of WC visit summary. Verbal provided to employer who verbalized understanding. WC visit summary faxed to 303.736.7767 with confirmation received. (smk51) (smk51)

DIAGNOSIS S51.812A Laceration without foreign body of left forearm, init encntr
Accident 10.30.17 07:00 Indust

TIME IN - 10:19

Signed by- Megan Milligan, P.A.-C

NURSE- smk51 COA- Alert/Amb

TIME OUT- 10:46

Cosigning MD- Jennifer A. Dwyer, D.O.

R&D- jms51-SYS

WC - Dx WC: Y

Disability: N

Date of Injury: 10/30/17

Full Duty Release Date: 10.31.17

Medications affect work: N

Medications affect work: N

