Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐

1a. Title X Only — Full Pay ☐ Partial Pay ☐ No Pay ☐

2a. Billing Provider TPI

2b. Billing Provider NPI

3. Provider Name

4. Eligibility Date (V or XX) (MM/DD/CCYY)

5. Family Planning No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial)

7. Address (Street, City, State)

7a. ZIP code

8. County of Residence

9. Date of Birth (MM/DD/CCYY)

10. Sex F ☐ M ☐

11. Patient Status — New Patient ☐ Established Patient ☐

12. Patient's Social Security Number - -

13. Race (Code #) ☐
White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5)
Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)

13a. Ethnicity ☐
Hispanic (5) Non-Hispanic (0)

14. Marital Status ☐
(1) Married (2) Never Married (3) Formerly Married

15. Family Income (All) $

15a. Family Size

16. Number Times Pregnant

17. Number Live Births

18. Number Living Children

19. Primary Birth Control Method Before Initial Visit ☐

20. Primary Birth Control Method at End of This Visit ☐

a=Oral Contraceptive; b=1-Month hormonal injection; c=3-Month hormonal injection; d=Cervical cap/diaphragm; e=Abstinence; f= Hormonal Implant; g=Male condom; h=Female condom; i=Hormonal/Contraceptive patch; j=Spermicide (used alone); k=Intrauterine device (IUD); l=Vaginal ring; m=Fertility awareness method (FAM); n=Sterilization; o=Contraceptive sponge; p=Other method; q=Method unknown; r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r) ☐

a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Preg; e=Infertile; f=Rely on Partner; g=Medical

22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a

23. Other Insurance Name and Address

24a. Insured's Policy/Group No.

24b. Benefit Code

25. Other Insurance Pd. Amt. $

25a. Date of Notification

26. Name of Referring Provider

27a. Referring Other ID

27b. Referring NPI

28. Level of Practitioner
Physician ☐ Nurse ☐ Mid Level ☐ Other ☐

29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)
1. _____ 3. _____
2. _____ 4. _____

30. Authorization Number

31. Date of Occurrence (MM / DD / CCYY)

32. A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Reserved for Local Use	D Procedures, Services, or Supplies CPT/HCPCS Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI
												32H(a) TPI 32H(b) NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed (V, X or XX) $

36. **Total Charges**

37. Signature of Physician or Supplier
Date:
Signed:

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

38a. NPI

38b. Other ID

39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.

Form Revised: January 2007