



MEDICAL MUTUAL OF OHIO

P.O. Box 6018
Cleveland, Ohio 44101-1018



VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION										
1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)			2. PATIENT'S DATE OF BIRTH			3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)				
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>			6. SUBSCRIBER'S CERTIFICATE NO.				
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.)			7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>			8. SUBSCRIBER'S GROUP NO.		RECIPROcity ← N →		
			10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>			11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED _____ DATE _____						11A. CHAMPUS SPONSOR'S		STATUS		BRANCH OF SERVICE
						<input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED				
PHYSICIAN OR SUPPLIER INFORMATION										
14. DATE OF:		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES		16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>		
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____			DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____					
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)					20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____					
21. NUMBER AND NAME OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE) _____					22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____					
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3 ETC. OR DX CODE						B. EPSDT YES <input type="checkbox"/> NO <input type="checkbox"/> FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO. _____				
24. A DATE OF SERVICE FROM TO		B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)			D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G T.O.S	H M
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PARTY THEREOF)					26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID	29. BALANCE DUE
32. YOUR PATIENT'S ACCOUNT NO.					30. YOUR SOCIAL SECURITY NO.		31. PHYSICIAN, SUPPLIER AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.			
					33. YOUR EMPLOYER ID NO.					

Signature of Physician (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PLACE OF SERVICE CODES:


- 1 – Inpatient Hospital
- 2 – Outpatient Hospital
- 3 – Doctor's Office
- 4 – Patient's Home
- 5 – Day Care Facility (PSY)
- 6 – Night Care Facility (PSY)
- 7 – Nursing Home
- 8 – Skilled Nursing Facility
- 9 – Ambulance
- 0 – Other Locations
- A – Independent Laboratory
- B – Ambulatory Surgical Center

- C – Residential Treatment Center
- D – Specialized Treatment Facility
- E – Comprehensive Outpatient Rehabilitation Facility
- F – Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 – Medical Care
- 2 – Surgery
- 3 – Consultation (Inpatient only)
- 4 – Diagnostic X-Ray
- 5 – Diagnostic Laboratory
- 6 – Radiation Therapy

- 7 – Anesthesia
- 8 – Assistant at Surgery
- 9 – Other Medical Service
- 0 – Blood or Packed Red Cells
- A – Used DME
- F – Ambulatory Surgical Center
- H – Hospice
- L – Renal Supplies in the Home
- M – Alternate Payment for Maintenance Dialysis
- N – Kidney Donor
- V – Pneumococcal Vaccine
- Y – Second Opinion on Elective Surgery
- Z – Third Opinion on Elective Surgery



MEDICAL MUTUAL OF OHIO*

DOE, JOHN
Subscriber Name

123456789
Certificate Number

123ABC
Group Number

F 19 4.00/1.00 D 034 12-31-92
Rx TypeChd AgeDed AmtAg CdlDays SupplyExp Date



P.O. Box 6018
Cleveland, Ohio 44101-1018



VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. SUBSCRIBER'S CERTIFICATE NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. SUBSCRIBER'S GROUP NO. RECIPROCITY ← N →
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.)	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
		11A. CHAMPUS SPONSOR'S STATUS <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED BRANCH OF SERVICE