

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																																
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										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																																																						
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										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO										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 <i>If yes, return to and complete item 9 a-d.</i>																																																						
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> 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)										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					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
1. _____										3. _____										NPI																																																						
2. _____										4. _____										NPI																																																						
3. _____										NPI																																																																
4. _____										NPI																																																																
5. _____										NPI																																																																
6. _____										NPI																																																																
25. FEDERAL TAX I.D. NUMBER										SSN EIN					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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																																						
SIGNED _____										DATE _____										a. NPI					b. _____					a. NPI					b. _____																																							

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

CalOptima Direct HCFA 1500 Claim Completion

1. **Provider ID and NPI Number *MUST*** be actively registered in our system as a CalOptima Direct Provider.
 - * The Provider ID Number, NPI Number and Tax ID Number that are registered in the CalOptima Direct Provider System *must* be used to bill.
 - * **EFFECTIVE DATES OF SERVICE 5/23/07:** The National Provider Identification Number and Tax ID Numbers that are registered in the CalOptima Direct Provider System *must* be used to bill. If you have not registered your NPI number, please email your NPI Information to NPI@caloptima.org.
 - * To verify these numbers *prior to billing* please call the Provider Enrollment unit at (714) 246-8468.

2. **Member Eligibility**
 - * Check eligibility through the IVR System (800) 463-0935 or AEVS (800) 456-2387; medi-cal website, be sure to keep the printout on file for documentation.
 - * Members in one of our Health Networks must refer to appropriate Health Network for billing instructions.

3. **Authorization Required Procedure Codes**
 - * The Authorization Required Procedure Codes List can be found in the medical management section in this manual.

4. **Timeliness**
 - * CalOptima has timeliness guidelines, which gives the provider one year from the date of service to submit a claim. If a claim is not submitted within the one year from the date of service, it will be denied for timeliness.
 - * The claim may be re-submitted with documentation showing that the claim was submitted timely for review (example; retro eligibility issues, authorization issues, etc.)
 - * The timeline for submitting a resubmission request is 6 months from the denial date on the original Remittance Advice (RA).

5. CalOptima Direct Claims Submission Addresses and Phone Numbers

CalOptima Direct Claims Original Claims and Resubmission Claims	CalOptima Direct Claims Over One Year Unit	CalOptima Direct Grievances	CalOptima Medi-Medi Crossover Claims (HCFA)
CalOptima Direct Claims Department P.O. Box 11037 Orange, CA 92856	CalOptima Direct Attn: Over One Year Unit P.O. Box 11037 Orange, CA 92856	CalOptima Direct Provider Grievance Unit P.O. Box 11033 Orange, CA 92856	EDS Corporation Attn: CalOptima Crossover Unit P.O. Box 15700 Sacramento, CA 92852-1700

Key **CalOptima Direct** Phone Numbers:
 Claims Inquiry 714-246-8885
 Case Management/Prior Auth 714-246-8475

Websites:
 Medi-cal – www.medi-cal.ca.gov
 CalOptima Direct – www.caloptima.org