# Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

**PATIENT**

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

**SUBSCRIBER / EMPLOYEE**

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X
Signed (Patient/Guardian) Date (MM/DD/YYYY)

**OTHER POLICIES**

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X
Signed (Employee/subscriber) Date (MM/DD/YYYY)

**BILLING DENTIST**

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed / Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: / Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither — Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

| Date (MM/DD/YYYY) | Tooth | Surface | Diagnosis Index # | Procedure Code | Qty | Description | Fee | Admin. Use Only |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

| | |
|---|---|
| Total Fee | |
| Payment by other plan | |
| Max. Allowable | |
| Deductible | |
| Carrier % | |
| Carrier pays | |
| Patient pays | |

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

# TAXI AUTHORIZATION/INVOICE

**Section 1: Authorization To Be Completed By Eligibility Worker**

Recipient's Name _____ Case Name _____ Case No. _____ Recipient I.D. No _____ Unit Control No. _____

Name of Taxi Provider _____ FAX No. _____ Phone No. _____

The Department of Human Services has determined that the above named individual is eligible for limited taxi services for the month of _____. Taxi services are restricted to the following destinations as indicated below:

Residence Address or otherwise indicated: _____ To: Provider #1: _____ Address: _____ Frequency _____

Provider # 2: _____ Address: _____ Frequency _____

Provider #3: _____ Address: _____ Frequency _____

Provider # 4: _____ Address _____ Frequency _____

Provider #5: _____ Address: _____ Freqency _____

Additional services have been authorized by _____ for transportation services limited to

_____

_____.

Any changes to this authorization form will nullify this agreement and the Department will not be responsible for any additional charges without the approval of the eligibility worker or a medical consultant. Should after hours emergency service be provided, the Department may authorize taxi services, provided the emergency is confirmed by a note from the physician or facility who provided the services.

Printed Name of Eligibility Worker _____ Eligibility Worker's Signature _____ Authorization Date _____ Phone No. _____ FAX No. _____

**Section 2: Invoice To Be Completed By Taxi Provider**

| | TAXI TRIP RECORD NUMBER | COLUMN 1 TOTAL CHARGES | | TAXI TRIP RECORD NUMBER | COLUMN 2 TOTAL CHARGES |
|---|---|---|---|---|---|
| 1 | | | 7 | | |
| 2 | | | 8 | | |
| 3 | | | 9 | | |
| 4 | | | 10 | | |
| 5 | | | 11 | | |
| 6 | | | 12 | | |
| | Column 1 Total | $ | | Column 2 Total | $ |
| | | | | Subtotal | $ |
| | | | | 4% Tax | $ |
| | | | | **AMOUNT DUE** | $ |

**I certify the above to be accurate and true.**

Printed Name of Authorized Agent _____ Authorized Agent's Signature _____ Provider Address _____ Date _____ Prov. Invoice No. _____

DHS 1135 (Rev. 04/97)

Original - Case Record
Copies - Client & Provider

**INSTRUCTIONS**
**DHS 1135**

**TAXI AUTHORIZATION/INVOICE**

PURPOSE:

The DHS 1135, Taxi Authorization/Invoice form shall be completed monthly by the eligibility workers (EWs) and taxi providers. This form is used to authorize taxi services for the "fee-for-service" recipients, who are medically certified to receive taxi services to obtain medical services. This form is intended to:

I. Inform recipients of their monthly eligibility for taxi services;

II. Inform taxi providers of recipients they are authorized to provide services for a specified calendar month; and

III. Inform ASO/BP that the EW authorized taxi services for a specified recipient, destination(s) and month.

Recipients are entitled to taxi services if their physical or mental condition could jeopardize the health and safety of the community if public transportation is used. The EW must assess the information contained on the DHS 1160 Screening Form for Transportation Service Request form to determine if the physician's recommendation for taxi service is justified. The EW will initiate the DHS 1135 if it is determined that the recipient is entitled to utilize taxi services.

Taxi service authorizations are limited from/to the residence or specified. "Point-of-pickup" and the nearest appropriate medical facility. Convenience will not be considered in determining taxi service authorizations. A MQD medical consultant must approve any travel, other than those indicated above.

Services not paid by Medicaid (without prior MQD medical consultant's approval) include, but not limited to the following:

I. Recipients who utilize the services of a provider other than the nearest one available;

II. Recipients who fail to cancel or be at any scheduled pickup location and time, which they requested;

III. Additional services rendered by taxi drivers assisting recipients upon entering or leaving the taxi or with their wheelchairs, and portable medical equipment (i.e. oxygen concentrators or tanks);

IV. Other services rendered by taxi drivers in cleaning the interior of their taxi in the event the recipient soils their vehicle;

V. "Waiting time" incurred by taxi drivers whenever recipients are not at the requested pickup location at the requested time; or

VI. Trips not authorized by the EW or by the MQD medical consultant.

GENERAL INSTRUCTIONS:

I. Form shall be written legibly or typed

II. Section 1 (Completed by the EW)

A. Authorize taxi services after determining requirements were met (via the DHS 1160).

B. Allow the recipient to select a taxi provider for each calendar month from the list of Medicaid approved taxi providers issued on the ICF by R. Iwata, dated03/20/91.

C. Have the recipient identify the name(s) and address (es) of their medical provider(s) that they are required to seek medical treatment from during that month. If any additional medical providers need to be listed on the DHS 1135, another form needs to be completed.

D. Confirm any additional services required with a medical consultant.

E. Authorizing emergency taxi/one-time service.

1. A supporting CHS 1160 is not required.

2. EW is to use available case information and consult with the medical provider to determine if the recipient is too ill or who's physical or mental condition makes it unsafe to use the bus or "curb-side-service" (handi-van),

F. Original form - filed in case record
Copy - faxed to recipient's taxi provider
Copy - mailed/given to recipient

III. Section 2 (Completed by the Taxi provider)

A. The section/unit will forward (fax or mail) the DHS 1135 form to the taxi provider for each recipient authorized to utilize taxi services for that month.

B. This form must be used as the invoice for payment to ASO/BP.

C. The authorized agent for the taxi provider shall verify that all the information on each of the DHS 1136 Taxi Trip Record form is completed. Verified information documented on the DHS 1136 is to be transposed onto the DHS 1135 form. ("OTHER CHARGES" and "REASON FOR OTHER CHARGES" - to be completed only if applicable).

D. All DHS 1136 forms listed on the DHS 1135 must be attached to the upper left back corner of this form.

E. Send the ORIGINAL and two (2) copies of the DHS 1135 (invoice) and the original copy of the listed DHS 1136 forms to ASO/BP within six (6) weeks from the last DHS 1136 service date.

F. Staple together and return all-"VOICED" DHS 1136 forms to ASO/BP. ("VOIDED" should be written on the face of these forms).

G. For emergency trips (without authorized DHS 1135):

1. Complete Section 2 of an unauthorized DHS 1135 for each emergency taxi service.

2. Attach the applicable DHS 1136 forms including that of the return trip form the emergency medical provider to the recipient's residence; and

3. Attach the written confirmation from the physician or facility that provided the emergency medical services and send to:

ASO/Benefit Payment Section
P.O. Box 339
Honolulu, Hawaii 96809-0339

IV. Processing of completed DHS 1135 and DHS 1136 forms.

A. ASO/BP will pre-audit and process all forms completed correctly for payment.

B. ASO/BP will return incomplete forms to the taxi provider for correction, completion, and resubmittal.

C. ASO/BP will forward all other DHS 1135 and DHS 1136 forms to MQD/Medical Standards Branch for appropriate action.

SPECIFIC INSTRUCTIONS:

I. Section 1 (Completed by the EW)

A. Recipient's Name — Last, First, Middle Initial

B. Case Name — Last, First

C. Case Number — Self-explanatory

D. Recipient I.D. No. — Self-explanatory

E. Unit Control No. — 6 data elements (see below)

| | Alpha | Num | Num | Num | Num | Num |
|---|---|---|---|---|---|---|
| Element number | 1 | 2 | 3 | 4 | 5 | 6 |

Example: M7108111130S

| | | | |
|---|---|---|---|
| 1 (1 digit field) | = | O | Oahu |
| | = | H | Hawaii |
| | = | M | Maui |
| | = | K | Kauai |
| 2 (1 digit field) | = | 7 | Last digit of year (e.g. 1997) |
| 3 (3 digit field) | = | 106 | (e.g. .106 is the Julian date of the 106th day the year on which the DHS 1135 was authorized). |
| 4 (3 digit field) | = | 111 | Section/Unit (e.g. MQD/Oahu Applications Section is 111) |
| 5 (2 digit field) | = | 13 | 13 is the workers number in the section/unit. |
| 6 (2 digit field) | = | 05 | (e.g. 05 is the 5th number of DHS 1135 forms authorized by the EW on 04/16/97). |

F. Name of Taxi Provider — Refer to list of approved providers on ICF By R. Iwata "IC Medicaid Taxi Providers" Dated 03/20/97.

G. FAX No. — Fax number of the taxi provider.

| | | | |
|---|---|---|---|
| H. | Phone No. | Phone number of the taxi provider. | |
| I. | Service for the month of ____ | Authorized month (e.g. April 1997) | |
| J. | Residence Address or Otherwise indicated | Example 1:<br>Example 2:<br>Example 3: | 820 Mililani St., Apt. 717<br>Aloha Hotel* 100 Mahalo St.<br>Honolulu Int'l Airport*<br>100 Nimitz Hwy. |
| K. | Provider #1 to 5 Address | Example 1:<br>Example 2: | Dr. John Smith 100 Castle Rd.<br>Queens Medical Center<br>100 Punchbowl St. |
| L. | Authorized by: | Example 1: | Dr. G. Batten, MSB |
| M. | Services Limited To: | Example 1:<br>Example 2: | Longs Drug Store at<br>1330 Pali Hwy.<br>From and to Honolulu Int'l Airport, Queens Medical Center, and Pagoda Hotel.* |
| N. | Printed Name of Eligibility Worker | Self-explanatory | |
| O. | Eligibility Worker's Signature | Self-explanatory | |
| P. | Authorization Date | Self-explanatory | |
| Q. | Phone No. | Self-explanatory | |
| R. | FAX No. | Self-explanatory | |

* For recipients on the neighbor islands requiring medical treatment on Oahu, Residence Address or Otherwise Indicated would include the addresses of hotels & Airports previously authorized by the MQD medical consultants.

II. Section 2 (Completed by the Taxi Provider)

| | | |
|---|---|---|
| A. | Taxi Trip Record Number | (e.g. A000123) |
| B. | Total Charges | (e.g. $ 7.50) |
| C. | Column 1 Total | (e.g. $125.75) |
| D. | Column 2 Total | (e.g. $ 35.80) |

| | | |
|---|---|---|
| E. | Subtotal | (e.g. $161.55) |
| F. | Tax (current rate 4%) | (e.g. $ 6.46) |
| G. | Amount Due | (e.g. $168.01) |
| H. | Printed Name of Authorized Agent | Name of person preparing this form for the taxi Provider. |
| I. | Signature of Authorized Agent | Self-explanatory |
| J. | Provider Address | Mailing Address |
| K. | Date | Self-explanatory |
| L. | Provider Invoice Number | Provider control number assigned by the taxi provider to identify each invoice submitted to Fiscal Management Office/Benefit Payment (FMO/BP) |

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

MED-QUEST DIVISION

# TAXI TRIP RECORD

_____ A-_____
DATE FORM CONTROL NO.

_____ _____
ADDRESS FROM ODOMETER READING

_____ _____
ADDRESS TO ODOMETER READING

_____ $_____ $_____
TOTAL MILEAGE TOTAL METER COST OTHER CHARGES

REASON FOR OTHER CHARGES_____

_____

_____ _____
DRIVER'S SIGNATURE PRINTED NAME OF DRIVER

_____ _____ _____
RECIPIENT'S SIGNATURE RECIPIENT I.D. NO. UNIT CONTROL NO.

**INSTRUCTIONS**
**DHS 1136**

**TAXI TRIP RECORD**

**PURPOSE:**

The **DHS 1136** Taxi Trip Record form is used by the Medicaid approved taxi drivers to record taxi services provided to the medically certified fee-for-service recipients in obtaining medical services. This form must be attached to the completed **DHS 1135** Taxi Authorization/Invoice form and submitted to Fiscal Management Office/Benefit Payment/Medical Section (FMO/BPMS) for payment processing.

**GENERAL INSTRUCTIONS:**

I. Form shall be written legibly in ink.

II. This form is used:

A. to verify that a currently authorized **DHS 1135** is on file for that individual for that month of service;

B. to confirm that the pickup and drop off locations are listed on the individual's **DHS 1135** for that month;

C. to relay to their taxi driver, the time of the pickup, the pickup and drop off locations and the unit control no. (listed on the **DHS 1135**);

D. for after hours emergency taxi service without a currently authorized **DHS 1135**, the taxi driver must:

1. be shown a current Medical Assistance Identification Card or Medical Assistance Coupon with an expiration date not to exceed the taxi service date; and

2. receive a written confirmation from the physician or facility who will provide the emergency service.

**SPECIFIC INSTRUCTIONS:**

I. Taxi drivers upon being dispatched will complete the following information on the **DHS 1136** form:

| | | |
|---|---|---|
| A. | Date | Self explanatory |
| B. | Address From | Example 1: 820 Mililani St., Rm. 717<br>Example 2: Aloha Hotel *<br>100 No. Mahalo St. |
| C. | Address To | Example 1: Dr. John Smith<br>100 Castle Rd.<br>Example 2: Queen's Medical Center<br>100 Punchbowl St. |

II. Taxi drivers upon arrival at the pickup location shall request to see the recipient's Medical Assistance Identification Card or Medical Assistance Coupon and enter the recipient's I.D. number on the form.

| | |
|---|---|
| Recipient I.D. No. | Example: 0000010001 |

III. Taxi drivers before departing the pickup or origination address, must enter:

| | |
|---|---|
| Odometer Reading | Example: 12,321.6 mi. |

IV. Taxi drivers upon arrival at the drop off location will have recipients sign their names to attest to transportation services received by the taxi driver.

| | |
|---|---|
| Recipient's Signature | Self explanatory |

- For after hours emergency taxi service, shall request that the recipient provide or accompany the recipient in getting a written confirmation from the physician or facility who is providing the emergency service.

V. Taxi drivers, prior to leaving the drop off location shall complete the following information:

| | | |
|---|---|---|
| A. | Odometer Reading | Example: 12,337.6 mi. |
| B. | Total Mileage | Example: 16 miles |
| C. | Total meter cost | Example: $12.75 |
| D. | Other Charges | Do not complete unless authorized by the MQD medical consultant<br><br>Example: $2.50 |
| E. | Reason for Other | Do not complete unless authorized by the MQD medical consultant<br><br>Example 1: Longs Drug Store at 1330 Pali Hwy.<br><br>Example 2: From and to Honolulu Int'l Airport, Queen's Medical Center and Pagoda Hotel. * |
| F. | Driver's Signature | Self explanatory |
| G. | Printed Name of Driver | Last, First and Middle Initial |

- For recipients on the neighbor islands requiring medical treatment on Oahu, **Residence Address or Otherwise Indicated** would include the addresses of hotels and airports previously authorized by the MD medical consultants.

VI. Taxi driver will submit the completed **DHS 1136** to the taxi provider to file for payments. All voided **DHS 1136** must also be submitted to the taxi providers.

VII. The authorized agent for the taxi provider shall verify that all the information on each of the **DHS 1136** Taxi Trip Record form is completed. "OTHER CHARGES" and "REASON FOR OTHER CHARGES" – is to be completed only if applicable.

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Health Care Administration Division

(Embossed I.D. Card Information)

# HYSTERECTOMY ACKNOWLEDGEMENT

| Identification Number | Category Code | Sec. | FM Code | Patient's Full Name | Sex M ( ) F (X) | Birthdate / / |
|---|---|---|---|---|---|---|
| | | | | | | |

I have informed _____
Name of Person to Have Hysterectomy

or _____ orally and by this statement that
Name of Her Representative, If Applicable

the hysterectomy she is to have will render her permanently incapable of reproducing.

_____ _____
Signature of Person Obtaining Authorization To Perform the Hysterectomy — Date

---

## TO BE COMPLETED BY PATIENT OR HER REPRESENTATIVE

I acknowledge that I received the above information.

_____ _____
Signature of Person to Have the Hysterectomy — Date

Or, if applicable:

_____ _____
Signature of Her Representative — Date

DHS 1145 (6/89)

ATTACH TO CLAIM

**INSTRUCTIONS FOR**
**FORM 1145**

**HYSTERECTOMY ACKNOWLEDGEMENT**

A completed Hysterectomy Acknowledgement Form is required for all hysterectomies except those outlined in Part IV of this appendix. The form consists of patient information, provider certification that the required information was provided to the patient, and patient acknowledgement that the required information was received.

A. Patient Information (completed by attending physician or staff)

1. This area may be used to imprint patient information.

2. Enter the patient's Medicaid ID number exactly as shown on the Medicaid ID card. For HAWI recipients, enter the 10-digit recipient number. For non-HAWI recipients, enter the case number including the preceding alpha. Provide the FM code for non-HAWI recipients also.

   Patient has applied for Medicaid coverage but has not yet been approved, a statement such as "Medicaid Pending" must be entered in place of the ID number.

3. Enter the patient's last name, first name and middle initial as shown on the Medicaid ID card. Nicknames should not be used.

4. Enter the patient's date of birth, especially if the patient's coverage under Medicaid is still pending DHS approval.

B. Provider Certification (completed by attending physician or staff)

1. Enter the patient's full name, as shown in #3 above.

2. Provide the last name and first name of the patient's representative if the patient was not able to acknowledge receipt of the required information and sign the form. A spouse, parent, or other close relative may act as a representative and receive information on her behalf. In the event of an emergency, such as a ruptured uterus, a friend or even a nurse or other responsible hospital employee may receive the information.

3. The person who warned the patient or her representative of the consequences of the procedure and her subsequent inability to reproduce, and who obtained the patient's authorization to perform the hysterectomy must sign here. This may be the physician, surgeon, nurse, or other responsible medical personnel with adequate medical knowledge to answer the patient's questions, if any.

4. Indicate the date signed by the person who obtained authorization.

C. Patient Acknowledgement (completed by patient)

1. Patient should sign the form to confirm that she receive the required information regarding the procedure before the service was rendered.

2. The patient must indicate the date signed. The form should be signed prior to the surgery. However, if the patient signs the form after the surgery date, the patient must still have received the required medical information before the surgery and the language of the form must be manually changed to include statements such as "Information given before the operation" and "before the operation" in the physician's and patient's portion of the form.

3. The representative must sign if a representative made acknowledgement of the information.

4. The representative must indicate the date signed. The form must be signed prior to the surgery no later than the day of surgery prior to pre-operative preparations.

DEPARTMENT OF HUMAN SERVICES

DHS/Med-QUEST Division
Medical Standards Branch

# STERILIZATION REQUIRED CONSENT FORM

| Identification Number | Name of Health Plan | Patient's Full Name | Sex | Date of Birth |
|---|---|---|---|---|
| | | | M( ) F( ) | / / |

**NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.**

## CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____
Doctor or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am currently receiving or for which I may become eligible.

**I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.**

I was told about those temporary methods of birth control that are available and could be provided to me that will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____, The discomforts, risks
Name of Procedure

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____/_____/_____ . I, _____, hereby consent
Date of Birth Name of Patient

of my own free will to be sterilized by _____ by a method called _____.
Name of Licensed Physician Sterilization Procedure

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services, or employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

| Printed Name of Patient | Signature of Patient | Date |
|---|---|---|
| | | |

You are requested to supply the following information but it is not required: (check race and ethnicity designation)

( ) Black (not of Hispanic origin) ( ) Asian or Pacific Islander ( ) White (not of Hispanic origin)
( ) Hispanic ( ) American Indian or Alaskan native

## STATEMENT OF INTERPRETER

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understands this explanation.

| Printed Name of Interpreter | Signature of Interpreter | Date |
|---|---|---|
| | | |

## STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the consent form, I explained to him/her the nature of the _____,
Name of Patient Sterilization Procedure

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the patient that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the patient that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the patient is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

| Printed Name of Individual Obtaining Consent | Signature | Date |
|---|---|---|
| | | |

| Name of Facility | Address | Phone Number |
|---|---|---|
| | | |

## STATEMENT OF PHYSICIAN

Shortly before I performed a sterilization operation upon _____ on _____
Name of Patient Date of Sterilization

I explained to him/her the nature of the _____, the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure

the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the patient that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the patient is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

## SELECT ONLY ONE OPTION:

☐ A. At least 30 days have passed between date the patient signed this consent form and date the sterilization was performed.

☐ B. This sterilization was performed less than 30 days but more than 72 hours after date of the patient's signature on this consent form because of the following circumstances (check applicable box and complete requested information).

( ) Premature delivery. Patient's expected date of delivery is: _____

( ) Emergency abdominal surgery. (describe circumstances): _____

_____

| Signature of Physician | Date |
|---|---|
| | |

DHS 1146 (Rev. 04/99) Original Copy - Physician Second Copy - Patient Third Copy - Hospital/Clinic

**INSTRUCTION FOR**
**FORM 1146**

## STERILIZATION REQUIRED CONSENT FORM 1146

A. Patient Information (completed by physician or his staff prior to surgery)

1. Provide the identification numbers exactly as they appear on the ID card. If the patient applied to DHS for Medicaid coverage but has not yet been approved, a statement such as "Medicaid Pending" must be entered in place of the Medicaid ID number.

2. Provide the patient's last name, first name and middle initial; do not use nicknames.

3. Indicate the patient's sex.

4. Indicate the patient's date of birth. This is always required. The patient must be at least 21 years of age.

B. Patient's Consent to Sterilization (completed by physician, his staff or patient prior to surgery). For ease of completion, the person obtaining the consent may complete all information except the patient's signature and date.

1. Indicate the full name of the physician or clinic from which the patient requested sterilization information.

2. Identify the surgical procedure to be performed.

3. Enter the patient's date of birth (month/day/year) as previously entered in #4 above.

4. Enter the patient's full name as previously entered in #2 above. If the patient changed names, the current name may be entered; however, the former name must also be provided to verify that the patient is the same.

5. Provide the full name of the surgeon.

6. Indicate the method of sterilization to be performed.

7. Patient's signature is required.

8. Date signed by patient is required and must be 30 calendar days or more prior to the expected surgery date, but not more than 180 days. In cases of emergency abdominal surgery, this date must be at least 72 hours before the surgery date.

C. Interpreter's Statement (completed prior to surgery if applicable)

1. Indicate the language or dialect used to communicate to the patient the required information.

2. The interpreter must sign the form.

3. The date signed by the interpreter is required and must be at least 30 days but not more than 180 days before the surgery.

D. Statement of the Person Obtaining Consent (completed by the physician or his staff prior to surgery).

1. Enter the patient's full name.

2. Provide the method of sterilization as indicated in #6.

3. The person obtaining consent must sign the form.

4. Provide the date signed by the person obtaining consent.

5. Name of the facility must be provided if the person obtaining consent is a hospital or clinic employee.

6. Provide the address of the facility.

The Patient must be given a copy of the completed and signed form.

E. Physician's Statement.

The physician must complete this section AFTER the surgery to certify that shortly before performing the sterilization, the physician provided the individual with the Federally required information regarding the sterilization.

1. Enter the patient's full name.

2. Provide the sterilization date. This date must be 30 or more calendar days after the patient signed the consent form, but not more than 180 days. In cases of emergency abdominal surgery, this date must be at least 72 hours after the patient signed.

3. Provide the sterilization method. This should be the same as indicated in previous portions of the form.

4. If the 30-day waiting period was met, cross off paragraph #2. If the 30-day waiting period was not met, cross off paragraph #1 and complete paragraph #2.

5. Provide the original expected date of delivery if premature delivery resulted in sterilization within 30 days but more than 72 hours of the patient's consent.

6. Provide the circumstances if emergency abdominal surgery resulted in sterilization within 30 days but more than 72 hours of the patient's consent.

7. The provider who rendered the sterilization procedure must sign the form after the procedure was performed.

8. Indicate the date signed by the provider.

When completed, the original copy should be attached to the surgeon's claim, the second copy given to the patient as required by Federal regulations, and the third copy attached to the hospital claim for the hospital charges. The surgeon should make copies of the completed Form 1146 available to anesthesiologists, assistant surgeons and co-surgeons as all claims for sterilization services will be rejected unless there is evidence of a valid, signed Form 1146.

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

Please mail to:
Unit _____
Address: _____
Worker: _____

# REQUEST FOR INDIVIDUALIZED TRANSPORTATION SERVICES

| Last Name | First Name | M.I. | Case Name | Case No. | Date of Birth | Sex (M/F) |
|---|---|---|---|---|---|---|
| | | | | | | |

| Street Address | City/State | Zip Code | Telephone No. |
|---|---|---|---|
| | | | |

**I. CLIENT: THIS SECTION MUST BE THOROUGHLY COMPLETED OR IT WILL BE RETURNED TO YOU**

A. Are you able to use public transportation **or** can someone regularly transport you to obtain medical services? _____
(If you answer yes, you will not be eligible for individualized transportation services.) (**Yes** / **No**)

B. Explain why you should receive individualized transportation: _____

C. List the names of your medical providers, frequency and the locations for which your need individualized transportation:

D. I certify that the above information is true and accurate to the best of my knowledge.

| Signature of Recipient or Legal Guardian | Printed Name of Recipient or Legal Guardian | Date |
|---|---|---|
| | | |

**II. LICENSED PHYSICIAN: COMPLETE INDIVIDUALIZED TRANSPORTATION NEED ASSESSMENT**

A. Diagnoses:

1) _____ 2) _____ 3) _____

B. Provide an explanation of all physical and/or mental impairments: _____

C. Provide an explanation whether your patient's impairment(s) will be temporary or permanent: _____

D. List all assertive devices (i.e., **wheelchair, walker, cane, etc**.): _____

**III. LICENSED PHYSICIAN: COMPLETE CERTIFICATION OF INDIVIDUALIZED TRANSPORTATION REQUEST**

A. I certify that it is medically necessary for _____, to be granted access to:
Recipient's Name

**taxi** ____ **curb-to-curb(van/Handi-van)** ____ **door-through-door(handi-cab)** ____ services from _____ (Month/Year) to _____ (Month/Year)

| Signature of Licensed Physician | Printed Name of Physician | Address | Phone No. |
|---|---|---|---|
| | | | |

**AFTER COMPLETING SECTIONS II AND III, PLEASE MAIL FORM TO THE ADDRESS LISTED ON THE UPPER RIGHT CORNER**

**IV. WORKER: AUTHORIZATION IS TO BE COMPLETED AT EACH ELIGIBILITY REVIEW FOR A PERIOD NOT TO EXCEED ONE (1) YEAR**

APPROVAL _____ (**is**) (**is not**) GRANTED FOR _____ ( **taxi** / **curb-to-curb** / **door-through-door** ) FROM _____ (Month/Year) TO _____ (Month/Year)

| Signature of Eligibility Worker | Printed Name of Eligibility Worker | Date |
|---|---|---|
| | | |

DHS 1160 (Rev. 05/97)

**INSTRUCTIONS**
**DHS 1160**

**REQUEST FOR INDIVIDUALIZED TRANSPORTATION SERVICES**

## PURPOSE:

The **DHS 1160**, Request for Individualized Transportation Services form shall be used to substantiate and verify a recipient's request for individualized transportation services to obtain medical services. Individualized transportation is defined as any mode of transportation to and from a medical facility.

All requests for individualized transportation services must be completed on the DHS 1160. A completed DHS 1160 must include:

I. the recipient's request for transportation;

II. an individualized transportation need assessment completed by a licensed physician;

III. a statement from a licensed physician certifying the need for transportation; and

IV. an eligibility worker's (EW) authorization for appropriate transportation.

## EXCEPTIONS:

**Request for emergency/"one-time" taxi services due to an illness, injury or other emergency situation does not require the completion of this form. Also, door-through-door type transportation may be provided for client's transportation between medical institutions without a DHS 1160.**

## GENERAL INSTRUCTIONS:

I. Form shall be written legibly in ink or typewritten.

II. This form shall be used for:

A. the recipient to justify the need for individualized transportation;

B. the licensed physician to substantiate recipient's need for individualized transportation;

C. the licensed physician to certify the medical circumstances and the need for the appropriate mode of individualized transportation; and

D. the EW to determine eligibility for, mode of transportation and certify the period of individualized transportation.

III. Distribution:
Original - file in case record.
Copy - mail to recipient.
Copy - mail to individualized transportation provider (for curb-to-curb providers not on Oahu).

**SPECIFIC INSTRUCTIONS:**

I. The eligibility worker (EW) shall complete the upper right corner of this form with the name of the unit, address, and EW's name.

II. The EW shall also complete the heading section of the **DHS 1160** with the following information and forward to the recipient:

| | | |
|---|---|---|
| A. | Recipient's Name | Last, First, M.I. |
| B. | Case Name | Last, First |
| C. | Case Number | Self explanatory |
| D. | Birthdate | MM/DD/YY |
| E. | Sex | M = male<br>F = female |
| F. | Street Address | Self explanatory |
| G. | City/State | Self explanatory |
| H. | Zip Code | Self explanatory |
| I. | Telephone No. | Self explanatory |

III. The recipient/guardian shall complete the narrative portion of section **I** Client which is self-explanatory. The recipient/guardian shall also complete the following information and forward to their licensed physician:

| | | |
|---|---|---|
| A. | Signature of Recipient/Legal Guardian | Legal Signature |
| B. | Printed Name of Recipient/Legal Guardian | Self explanatory |
| C. | Date | Self explanatory |

IV. The licensed physician shall complete the narrative portion of **section II License Physician/Individualized Transportation Need Assessment** to substantiate recipient's need for individualized transportation, which is self-explanatory.

V. The licensed physician shall also complete **section III Licensed Physician: Certification of Individualized Transportation Request** to certify the medical circumstances, the need for the appropriate mode of individualized transportation, and the period transportation is needed. Upon completion of this section, the licensed physician will forward this form to the EW listed at the address on the upper right corner of this form:

| | | |
|---|---|---|
| A. | Recipient's name | First, M.I., Last |
| B. | Taxi, Curb-to-Curb,<br>Door-Through-Door | (Check appropriate mode of transportation) |
| C. | (Period of certification) | (FROM) = Month/Year<br>(TO) = Month/Year |
| D. | Signature of Licensed Physician | Self explanatory |
| E. | Printed Name of Licensed Physician | Self explanatory |
| F. | Address | Self explanatory |
| G. | Phone No. | Self explanatory |

VI. The EW shall complete section **IV Worker** with the following information regarding the eligibility for, mode of transportation, and the period of certification for individualized transportation services:

| | | |
|---|---|---|
| A. | Approval (is or is not) | Self explanatory |

| | | |
|---|---|---|
| B. | (Mode of transportation) | Taxi<br>Curb-to-Curb<br>Door-Through-Door |
| C. | (Period of certification) | (FROM) = Month/Year<br>(TO) = Month/Year |
| D. | Signature of Eligibility Worker | Self explanatory |
| E. | Printed Name of Eligibility Worker | Self explanatory |
| F. | Date | Self explanatory |

# HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

| | | |
|---|---|---|
| 1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (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 ☐ F ☐ | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ | 7. INSURED'S ADDRESS (No., Street) |
| CITY / STATE | 8. RESERVED FOR NUCC USE | CITY / STATE |
| ZIP CODE / TELEPHONE (Include Area Code) ( ) | | 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) YES ☐ NO ☐ | a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES ☐ NO ☐ | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC) | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d. |
| **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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | 15. OTHER DATE QUAL. MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. / 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L. | | 22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER |

PHYSICIAN OR SUPPLIER INFORMATION

| 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. EPSDT 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 | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐ | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 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.) SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. | | 33. BILLING PROVIDER INFO & PH # ( ) a. NPI b. | | |

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

**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.

**ACS**
**HAWAII STATE MEDICAID FEE FOR SERVICE PROGRAM**
365 NORTHRIDGE RD, SUITE 400 • ATLANTA, GA 30350
**PRESCRIPTION DRUG CLAIM**

| Identification Number [1] | Member's Name [2] | Date of Birth [3] |
|---|---|---|
| | | |

| Pharmacy NABP [4] | Pharmacy Name [5] | Physician's Name [6] | Physician's DEA # / Provider Medicaid ID # [7] |
|---|---|---|---|
| | | | |

Pharmacy Address [8]

| Other Drug or Liability Coverage [9] Yes ☐ No ☐<br>Name of Coverage _____ | Date of Accident [10] | Is the illness or injury:[11] Work Related Yes ☐ No ☐ Third Party? Yes ☐ No ☐<br>Automobile Yes ☐ No ☐ Other Accident? Yes ☐ No ☐ | ICF-MR/ICF/SNF? [12] Yes ☐ No ☐ |
|---|---|---|---|
| | | | |

| | | | | | | | | Submitted Charge [25] | Paid by TPL Amount [26] (Attach a copy of EOB) | TOTAL [27] |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | RX Number [13] | Metric Qty [14] | Days Supply [15] | NDC [16] __ __ __ __ __ / __ __ __ __ / __ __ | | | Diag. Code [17] | | | |
| | Date [18] | ☐New ☐Refill [19] | | Drug Name [20] | DAW Code [21] | Prior Authorization No. [22] | Reason for Refill Too Soon Override [23] | | ✓ if Cmpd.[24] ☐ | |
| 2 | RX Number | Metric Qty | Days Supply | NDC __ __ __ __ __ / __ __ __ __ / __ __ | | | Diag. Code | | | |
| | Date | ☐New ☐Refill | | Drug Name | DAW Code | Prior Authorization No. | Reason for Refill Too Soon Override | | ✓ if Cmpd. ☐ | |
| 3 | RX Number | Metric Qty | Days Supply | NDC __ __ __ __ __ / __ __ __ __ / __ __ | | | Diag. Code | | | |
| | Date | ☐New ☐Refill | | Drug Name | DAW Code | Prior Authorization No. | Reason for Refill Too Soon Override | | ✓ if Cmpd. ☐ | |
| 4 | RX Number | Metric Qty | Days Supply | NDC __ __ __ __ __ / __ __ __ __ / __ __ | | | Diag. Code | | | |
| | Date | ☐New ☐Refill | | Drug Name | DAW Code | Prior Authorization No. | Reason for Refill Too Soon Override | | ✓ if Cmpd. ☐ | |
| 5 | RX Number | Metric Qty | Days Supply | NDC __ __ __ __ __ / __ __ __ __ / __ __ | | | Diag. Code | | | |
| | Date | ☐New ☐Refill | | Drug Name | DAW Code | Prior Authorization No. | Reason for Refill Too Soon Override | | ✓ if Cmpd. ☐ | |
| 6 | RX Number | Metric Qty | Days Supply | NDC __ __ __ __ __ / __ __ __ __ / __ __ | | | Diag. Code | | | |
| | Date | ☐New ☐Refill | | Drug Name | DAW Code | Prior Authorization No. | Reason for Refill Too Soon Override | | ✓ if Cmpd. ☐ | |

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. I hereby agree to keep such records as are necessary to fully disclose the extent of service provided under the State's Title XIX plan and to furnish such information regarding any payments claimed above as the State agency may request.

_____ _____
Provider's Signature Date

**Use For ACS Only**

Form 204 (10/02)

# Hawaii State Medicaid Fee For Service Program
# 204 Claim Form Instructions (10/02)

1. **Identification Number:** Enter the member's identification number.
2. **Member's Name:** Enter the member's name: first and last name.
3. **Date of Birth:** Enter the member's date of birth: mm/dd/yyyy.
4. **Pharmacy NABP:** Enter the pharmacy NABP.
5. **Pharmacy Name:** Enter the name of the pharmacy.
6. **Physician's Name:** Enter the name of the physician.
7. **Physician's DEA #/ Provider Medicaid ID #:** Enter either the physician's DEA number or the Provider's Medicaid ID number.
8. **Pharmacy Address:** Enter the address of the pharmacy, including city and zip code.
9. **Other Drug or Liability Coverage:** If the member does not have other drug or liability coverage, check **No** otherwise, **Yes** and enter the name of the other coverage.
10. **Date of Accident:** Enter the date of the accident or injury.
11. **Is the illness or injury:** Check whether the injury was work related, third party, an automobile accident, or another type of accident.
12. **ICF-MR/ICF/SNF:** Check whether or not ICF-MR/ICF/SNF.
13. **RX Number:** Enter the prescription number.
14. **Metric Qty:** Enter the metric quantity of the prescription; include the decimal amount where applicable.
15. **Days Supply:** Enter the number of days supplied for this prescription.
16. **NDC:** Enter the NDC number, #####-####-##.
17. **Diag. Code:** Enter the diagnosis code for the claim, ###.#.
18. **Date:** Enter the date of service, MM/DD/YYYY.
19. **New/Refill:** Check whether this is a new prescription or a refill.
20. **Drug Name:** Enter the name of the drug prescribed.
21. **DAW Code:** Enter the dispense as written code, such as 0,1,5, or 7.
22. **Prior Authorization No:** Enter the prior authorization number, ##########.
23. **Reason for Refill Too Soon Override:** Enter the reason for overriding a refill too soon: Lost/Stolen, Vacation, Additional Therapy Authorized, Change in Dose, Readmission to LTC facility
24. **Compd:** If this is a compound, check the box.
25. **Submitted Charge:** Enter the amount of the charge submitted.
26. **Paid by TPL Amount:** Enter the amount paid by a third party. Attach a copy of the Explanation of Benefits.
27. **Total:** Enter the total amount for this drug: Submitted Charge minus the amount paid by TPL if applicable.

*Note: Please **boldly label** on the top of paper claim if any of the following apply:*

Early Refill
Vacation
Home Infusion
TPL
Spend down
Elig problem
Coupon
Dx Code
MD Specialty
Mandatory Brand

Standard Register ® ZIPSET® F3 91733

[redacted]

HAWAII STATE MEDICAID (Title XIX) PROGRAM
P.O. BOX 1220, HONOLULU, HI 96807-1220

REFER TO INSTRUCTIONS ON REVERSE SIDE

A. TRANSPORTATION PROVIDER'S INVOICE NUMBER

# AIR TRANSPORTATION REQUEST FOR PRIOR AUTHORIZATION AND TRANSPORTATION PROVIDER CLAIM FORM

| 1. IDENTIFICATION NUMBER | 2. CATEGORY | 3. SEC. | 4. FM CODE | 5. PATIENT'S FULL NAME | 6. SEX MALE | FEMALE | 7. BIRTHDATE Mo. | Day | Yr. | 8. SERVICE DATES FROM Mo. | Day | TO Mo. | Day | Yr. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |

| 8. DATE I.D. CARD EXPIRES | 9. UNIT | 10. WORKER | C. TRANSPORTATION PROVIDER | D. PROVIDER NO. ✓ DIGIT | PRI. DIAG. | SEC. DIAG. |
|---|---|---|---|---|---|---|
| | | | | — | | |

| 11. SUBSCRIBER OR CASE NAME AND ADDRESS | ADDRESS (IF NOT IN THE STATE OF HAWAII) | B1 | B2 | B3 | B4 | B5 | B6 |
|---|---|---|---|---|---|---|---|
| | CITY STATE ZIP CODE | B7 | B8 | B9 | B10 | B11 | B12 |

12. EPSDT REFERRAL ☐ YES ☐ NO — COMPLETION REQUIRED

13. OTHER MEDICAL OR LIABILITY COVERAGE? ☐ YES ☐ NO
NAME OF CARRIER:

14. DATE OF ACCIDENT

15. IS THE ILLNESS OR INJURY:
WORK RELATED? YES ☐ NO ☐ THIRD PARTY? YES ☐ NO ☐
AUTOMOBILE? YES ☐ NO ☐ OTHER? YES ☐ NO ☐

16. REQUESTING PHYSICIAN PROVIDER NUMBER

| E. STATEMENT OF SERVICES RENDERED | HCPCS CODE | MODIFIER CODE | F. CHARGES | NO OF VISITS | POS |
|---|---|---|---|---|---|
| DATE: ☐ ONE WAY | A0140 | | | | 0 |
| ☐ ROUND TRIP | A0140 | | | | 0 |
| G. TAX | Z9020 | | | | |
| TOTAL CHARGES ▶ | | | | | |
| H. LESS PAID BY PATIENT | Z9022 | | | | |
| I. OTHER MEDICAL COVERAGE | Z9014 | | | | |

J. 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. I hereby agree to keep such records as are necessary to fully disclose the extent of services provided under the State's Title XIX plan and to furnish such information regarding any payments claimed above as the State agency may request.

TRANSPORTATION PROVIDER'S SIGNATURE _____ DATE ___/___/___

## THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

REQUEST IS BEING MADE FOR AIR TRANSPORTATION 17. FROM _____ CITY _____ 18. DATE OF TRAVEL _____

TO _____ 19. CITY: _____ 20. HOSPITAL: _____ 21. PHYSICIAN _____

22. EMERGENCY ☐ YES ☐ NO 23. TYPE OF TICKET ☐ ONE WAY ☐ ROUND TRIP 24. ATTENDANT NEEDED ☐ YES ☐ NO 25. TYPE TICKET ☐ ONE WAY ☐ ROUND TRIP

REFER PATIENT/ATTENDANT TO DHS CASEWORKER IF LODGING AND/OR FOOD IS REQUIRED.

26. DIAGNOSIS: _____

27. RECOMMENDED TREATMENT: _____

28. CHECK APPLICABLE BLOCKS:
PATIENT IS CONFINED TO A WHEELCHAIR ☐ YES ☐ NO STRETCHER ☐ YES ☐ NO
OXYGEN WILL BE REQUIRED IN FLIGHT ☐ YES ☐ NO OTHER LIFE SUPPORT ASSISTANCE MAY BE REQUIRED IN FLIGHT ☐ YES ☐ NO
URGENT MOVEMENT IS REQUIRED ☐ YES ☐ NO MOVEMENT BY AIR AMBULANCE IS REQUIRED ☐ YES ☐ NO

29. COMMENTS _____

MO. / DAY / YR

30. REQUESTING PHYSICIAN TYPED OR PRINTED NAME 31. PHYSICIAN SIGNATURE 32. DATE

**NOTE: Approval of authorization is not a guarantee for payment. Provider must be certified by Medicaid, and the patient must be eligible for Medicaid benefits when services are rendered. Check patient's Medicaid I.D. card to verify eligibility status. Medical authorization expires 30 days from date of DHS Medical Consultant's signature.**

## THIS SECTION TO BE COMPLETED BY DHS MEDICAL CONSULTANT

MEDICAL AUTHORIZATION IS: 33. ☐ APPROVED 34. ☐ NOT APPROVED 35. ☐ DEFERRED FOR THE FOLLOWING:

36. PATIENT EMERGENCY ☐ YES ☐ NO 37. TYPE TICKET ☐ ONE WAY ☐ ROUND TRIP 38. ATTENDANT NEEDED ☐ YES ☐ NO 39. TYPE TICKET ☐ ONE WAY ☐ ROUND TRIP

40. COMMENTS: _____

41. DATE _____ 42. DHS MEDICAL CONSULTANT _____

**NON-EMERGENCY:** SEND ALL COPES TO DHS MEDICAL CONSULTANT, P.O. BOX 339, HONOLULU, HI 96809
**EMERGENCY:** SEND ORIGINAL ONLY TO DHS MEDICAL CONSULTANT
**AIR AMBULANCE EMERGENCY:** GIVE ALL COPIES TO AIR AMBULANCE CREW

FORM 208 (REV. 8/96) (06)

THIS COPY TO BE RETAINED BY DHS-HCAD

**SHADED AREAS ARE TO BE COMPLETED BY TRANSPORTATION PROVIDER ONLY**

**FOR NON-EMERGENCY SITUATIONS**

**REQUESTING PHYSICIAN**

1. Complete the following patient eligibility information from the patient's Medicaid identification card:

   Identification number, patient's name, sex, birth date, ID card expiration date, and case name. Coupon cases also require completion of the category code and section number. For newborns, if the newborn does not have an identification number, enter the eligible mother's identification number and FM 99.

2. Check the applicable EPSDT Referral block. "YES" must be checked when the patient is being referred for treatment or diagnosis of a condition discovered during an EPSDT examination.

3. Indicate if the patient has other medical or liability coverage, name of the carrier, date of accident if applicable, and if the illness or the injury was related to work, automobile, third party or other. Enter the requesting physician provider number.

4. Complete the transportation request portion indicating cities, date of travel, hospital, and physician or provider where patient is being sent.

5. Indicate "no" for emergency, whether attendant required or not, and whether ticket should be one way or roundtrip. Refer the patient/attendant to the DHS caseworker if lodging or food is required.

6. Provide the diagnosis and recommended treatment.

7. Print or type the physician name, sign, and date this form.

8. Forward all four copies to the Fiscal Agent at P.O. Box 2561, Honolulu, Hawaii 96804-2561.

9. If the travel is of a urgent nature (same day travel), the Form 208 must be faxed to the Medicaid Fiscal Agent at (808) 952-5562 and the Med-QUEST Division will contact the requesting provider by phone and/or fax.

10. If the request is approved, a copy will be returned to the physician. Either the provider or the patient should contact the Med-QUEST division to make the appropriate airlines reservations. Airlines should not be contacted directly.

11. The Form 208 will serve only as the authorization for travel. Airline carriers will no longer accept the Form 208 as an airline ticket. All travel must be ticketed through the Med-QUEST Division.

**DHS MEDICAL CONSULTANT**

1. Review the information on the form and approve, disapprove or defer as appropriate.

2. Return a copy to the requesting physician.

**TRANSPORTATION SERVICES PROVIDER**

1. This form only serves as an authorization for travel. Do not accept this form as an airline ticket. Reservations must be coordinated with the Med-QUEST Division.

| 1 | 2 | 3a PAT. CNTL. # | 4 TYPE OF BILL |
|---|---|---|---|
| | | b. MED. REC. # | |
| | | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM / THROUGH | 7 |

| 8 PATIENT NAME | a | 9 PATIENT ADDRESS | a |
|---|---|---|---|
| b | | b | c / d / e |

| 10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | CONDITION CODES 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 ACDT STATE | 30 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | |

| | 31 OCCURRENCE CODE / DATE | 32 OCCURRENCE CODE / DATE | 33 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE SPAN CODE / FROM / THROUGH | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37 |
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| a | | | | | | | a |
| b | | | | | | | b |

| 38 | | 39 VALUE CODES CODE / AMOUNT | 40 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT |
|---|---|---|---|---|
| | | a | | |
| | | b | | |
| | | c | | |
| | | d | | |

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 |
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| 23 | | PAGE ____ OF ____ | CREATION DATE | | TOTALS | | | | 23 |

| | 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | |
|---|---|---|---|---|---|---|---|---|
| A | | | | | | | 57 | A |
| B | | | | | | | OTHER | B |
| C | | | | | | | PRV ID | C |

| | 58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|---|
| A | | | | | A |
| B | | | | | B |
| C | | | | | C |

| | 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME |
|---|---|---|---|
| A | | | A |
| B | | | B |
| C | | | C |

| 66 DX | 67 | A | B | C | D | E | F | G | H | 68 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | I | J | K | L | M | N | O | P | Q | |

| 69 ADMIT DX | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | 72 ECI | a | b | c | 73 |
|---|---|---|---|---|---|---|---|---|---|---|

| 74 PRINCIPAL PROCEDURE CODE / DATE | a. OTHER PROCEDURE CODE / DATE | b. OTHER PROCEDURE CODE / DATE | 75 |
|---|---|---|---|
| c. OTHER PROCEDURE CODE / DATE | d. OTHER PROCEDURE CODE / DATE | e. OTHER PROCEDURE CODE / DATE | |

| 80 REMARKS | 81CC | | |
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| | a | | |
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| 76 ATTENDING | NPI | QUAL | |
| LAST | | FIRST | |
| 77 OPERATING | NPI | QUAL | |
| LAST | | FIRST | |
| 78 OTHER | NPI | QUAL | |
| LAST | | FIRST | |
| 79 OTHER | NPI | QUAL | |
| LAST | | FIRST | |

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**UB-04 NOTICE:** **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

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SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS