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| 2 | | 3 PATIENT CONTROL NO. | | | | 4 TYPE OF BILL | |
| 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM | THROUGH | 7 COV. D. | 8 N-C.D. | 9 C-I.D. | 10 L-R.D. | 11 |

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| 12 PATIENT NAME | | | | | | | | | | | | 13 PATIENT ADDRESS | | | | | | | | | | | |
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| 14 BIRTHDATE | 15 SEX | 16 MS | 17 DATE | ADMISSION | | | | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | | | | 24 25 26 27 28 29 30 31 | | | | | | | |
| | | | | 18 HR | 19 TYPE | 20 SRC | | | | | | | | | | | | | | | |

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| 32 OCCURRENCE DATE | 33 CODE | 34 OCCURRENCE DATE | 35 CODE | 36 OCCURRENCE DATE | 37 CODE | OCCURRENCE SPAN FROM THROUGH | | 37 A B C | | | | | | | | | | | | | |
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| | | | | | 39 CODE | VALUE CODES AMOUNT | 40 CODE | VALUE CODES AMOUNT | 41 CODE | VALUE CODES AMOUNT | | | | | | | | | | | | | | |
| | | | | | a | . | | . | | . | | | | | | | | | | | | | | |
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| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
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| 50 PAYER | | | 51 PROVIDER NO. | | | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | | 55 EST. AMOUNT DUE | | 56 | |
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57 **DUE FROM PATIENT** ▶

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| 58 INSURED'S NAME | | | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO. | | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | | | |
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| 63 TREATMENT AUTHORIZATION CODES | | | 64 ESC | 65 EMPLOYER NAME | | | 66 EMPLOYER LOCATION | | | | |
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| 67 PRIN. DIAG. CD. | 68 CODE | 69 CODE | 70 CODE | OTHER DIAG. CODES | | | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78 |
| | | | | 71 CODE | 72 CODE | 73 CODE | | | | | |

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| 79 P.C. | 80 PRINCIPAL PROCEDURE CODE | DATE | 81 OTHER PROCEDURE CODE | DATE | OTHER PROCEDURE CODE | DATE | 82 ATTENDING PHYS. ID | | | | |
| | | | A | | B | | | | | | |
| | OTHER PROCEDURE CODE | DATE | OTHER PROCEDURE CODE | DATE | OTHER PROCEDURE CODE | DATE | 83 OTHER PHYS. ID | | | | |
| | C | | D | | E | | A | | | | |
| | | | | | | | OTHER PHYS. ID | | | | |
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| 84 REMARKS | | | | | | | | | | | |
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| 85 PROVIDER REPRESENTATIVE | | | | | | | | | | 86 DATE | |
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UNIFORM BILL:**NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or 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 particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
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 Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.
5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing 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 their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

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.

9. For CHAMPUS purposes:

This is to certify that:

- (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance 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 coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS 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 but excluding contract surgeons or other personnel employed by the Uniformed Services through 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 the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, 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. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS