MEDICAL MUTUAL OF OHIO®

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

[redacted]

VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2. PATIENT'S DATE OF BIRTH

3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. PATIENT'S SEX
MALE ☐ ☐ FEMALE

6. SUBSCRIBER'S CERTIFICATE NO.

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. SUBSCRIBER'S GROUP NO.

RECIPROCITY
N

9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. ACCIDENT
AUTO ☐ ☐ OTHER

11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

11A. CHAMPUS SPONSOR'S

STATUS	☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED	BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED DATE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:

ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16A. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NUMBER AND NAME OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ ☐ NO CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3 ETC. OR DX CODE
1.
2.
3.
4.

B.
EPSDT YES ☐ ☐ NO
FAMILY PLANNING YES ☐ ☐ NO
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G T.O.S	H
									M
									M
									M

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PARTY THEREOF)

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY)
YES ☐ ☐ NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN, SUPPLIER AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER ID NO.

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

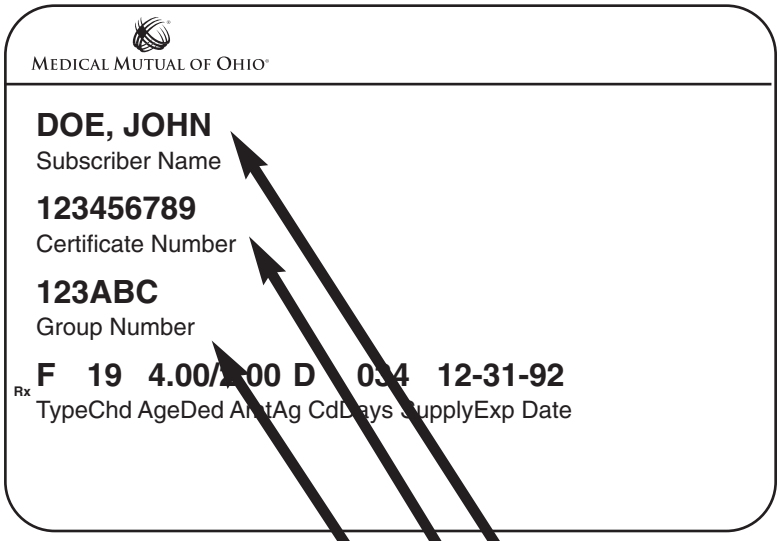
NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PLACE OF SERVICE CODES:

1 – Inpatient Hospital
2 – Outpatient Hospital
3 – Doctor's Office
4 – Patient's Home
5 – Day Care Facility (PSY)
6 – Night Care Facility (PSY)
7 – Nursing Home
8 – Skilled Nursing Facility
9 – Ambulance
0 – Other Locations
A – Independent Laboratory
B – Ambulatory Surgical Center
C – Residential Treatment Center
D – Specialized Treatment Facility
E – Comprehensive Outpatient Rehabilitation Facility
F – Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

1 – Medical Care
2 – Surgery
3 – Consultation (Inpatient only)
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistant at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
F – Ambulatory Surgical Center
H – Hospice
L – Renal Supplies in the Home
M – Alternate Payment for Maintenance Dialysis
N – Kidney Donor
V – Pneumococcal Vaccine
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery



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4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ ☐ FEMALE	6. SUBSCRIBER'S CERTIFICATE NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. SUBSCRIBER'S GROUP NO. **RECIPROCITY** N
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO B. ACCIDENT AUTO ☐ ☐ OTHER	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 11A. CHAMPUS SPONSOR'S STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED BRANCH OF SERVICE