

2017 Claims Form		1. Please use: <input type="checkbox"/> Family Planning Program (XXX) <input type="checkbox"/> DEHS Family Planning Program (DFPP)		<input type="checkbox"/> FHC <input type="checkbox"/> DEHC	2a. DFPP only: <input type="checkbox"/> Partial Pay <input type="checkbox"/> No Pay	2b. Billing Periods: TP1 2c. Billing periods: NPP
		3. Provider Name			4. Billing/Invoicing Dates (mm/yyyy)	
6. Patient's Name (Last Name, First Name, Middle Initial)			7. Address (Street, City, State)			7a. ZIP Code
8. County of Residence		9. Sex of Birth (M/F/Others)	10. Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	11. Patient Status <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient		12. Patient's Social Security Number
13. Repeat/Case # ()	13a. Date of Case ()	13b. Date of Discharge ()	13c. Antepartum/Postpartum () Antepartum/Postpartum () Antepartum only ()	13d. Admission ()	13e. Date of Non-Admission ()	13f. Medical Status <input type="checkbox"/> Prenatal <input type="checkbox"/> Postnatal <input type="checkbox"/> Postpartum <input type="checkbox"/> Postmenstrual
14. Family Income (Last 12)				15a. Family Size		
16. Number Times Pregnant			17. Number Live Births		18. Number Living Children	
19. Primary Birth Control Method Before Initial Visit ()		19a. Oral Contraceptives (a) Most hormonal options (b) Most hormonal options (c) Contraceptive injection (d) Contraceptive implant		19b. Intrauterine Device (IUD) (a) Copper IUD (b) Hormonal Intrauterine Device (Mirena) (c) Contraceptive sponge		19c. Other method (a) Withdrawal (b) Natural methods (c) Other method (if used for 12+ consecutive cycles)
20. Primary Birth Control Method at End of this Visit ()		20a. Contraceptive injection (a) Contraceptive injection (b) Contraceptive implant		20b. Contraceptive device (IUD) (a) Copper IUD (b) Hormonal Intrauterine Device (Mirena) (c) Contraceptive sponge		20c. Other method (a) Withdrawal (b) Natural methods (c) Other method (if used for 12+ consecutive cycles)
21. If No Method Used at End of this Visit, Give Reason (Required only if FHC or F) <input type="checkbox"/> Infidelity, <input type="checkbox"/> Infirmity, <input type="checkbox"/> Infecundation, <input type="checkbox"/> Pregnancy, <input type="checkbox"/> Contraceptive Prog. Term, <input type="checkbox"/> Seeking Prog., <input type="checkbox"/> Infertility, <input type="checkbox"/> Infidelity on Patient, <input type="checkbox"/> Other ()						
22. Is there Other Insurance Available? <input type="checkbox"/> Yes <input type="checkbox"/> No			23. Other Insurance Name and Address			
24a. Insurer's Policy Group No.		24b. Insurer Code		25. Other Insurance PG. Amt. \$		26a. Date of Identification
26. Name of Referring Provider		27a. Referring Office ()			28. Level of Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> MD-Level <input type="checkbox"/> Other	
		27b. Referring NPI				
29. Diagnosis Code (ICD-9-CM, or ICD-10-CM)				30a. ICD-9-CM		30b. Authorization Number
a. _____		b. _____		c. _____		31. Date of Submission (mm/yyyy)
d. _____		e. _____		f. _____		
g. _____		h. _____		i. _____		
32. Billing Details						
32a. Date of Service (MM/YY)		32b. Place of Service		32c. Type of Service		32d. Procedure, Service, or Supplies (ICD-9-CM)
32e. Rate or Charge (Quantity)		32f. Charge		32g. Referring Provider #		
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2017 Claim Form Tmhp

CH Cherryholmes



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