SimpleTherapy® | SimpleMSK

MEDICAL CLAIM FORM

PATIENT INFORMATION

1. Patient Name:	2. Patient's Date of Birth:	3. Patient's ID #:
4. Patient's Sex: ☐ Male ☐ Female	5. Patient's Phone:	6. Patient's Relation to Employee: ☐ Self ☐ Spouse/Domestic Partner ☐ Child ☐ Other
7. Patient's Address (Street, City, State, Zip Code): ☐ Check Here if New Address		
8. Insured's Name:	9. Insured's ID Number:	10. Insured's Phone:
11. Insured's Address (Street, City, State, Zip Code):		

12. Other Health Insurance Coverage: Is patient covered by any other Health Plan? ☐ Yes ☐ No (If "Yes," complete information below)

Name of Other Carrier: ____ Patient's Identification #: ________________

Name of Insured: ____ Insured's Employer: _____________________________

Effective Date of Coverage: _______ Termination Date of Coverage: ________

13. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signed (Patient or Patients Legal Guardian if a Minor) Date

PHYSICIAN INFORMATION

14. Name & Title of Rendering Physician:

15. Office Address of Rendering Physician:	16. Office Phone of Rendering Physician:

17. Diagnosis or Nature of Illness or Injury (Relate to Procedure Code in Column D):

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

Place of Service Codes:

11 – Doctor's Office
72 – Rural Health Clinic
20 – Urgent Care Facility
22 – Outpatient Hospital
21 – Inpatient Hospital
23 – Emergency Room
24 – AMB SURG CTR
31 - Skilled Nursing Facility
32 – Nursing Facility
33 – Custodial Care Facility
41 – Ambulance
51 – INPT PSYCH Facility
52 – PHP PSYCH Facility
53 – Community Mental Health CRT
55 – Substance Abuse RTC
56 – PSYCH RTC
57 – Non-Residential Substance Abuse

18. A-Date of Service: From	To	B-Place of Service	C-Description of Medical Services or Supplies Furnished for Each Date Given (CPT Procedure Code)	D-Diagnosis Pointer (from Box 17)	E-Charges		F-Days or Units

19. Your Patient's Account Number:	20. Accepts Assignment (Government Claims Only): ☐Yes ☐No	21. Total Charges:	22. Amt Paid:
23. Signature of Physician or Supplier - Including Degree(s) or Credential(s):	24. Tax Identification Number:	26. Physician's, Supplier's, and/or Group Name, Address, Zip Code, & Telephone #:	
	25. Taxable Entity Name (If different than Box 25):		