

TRANSCRIPTION LABELS

TLD-12P
12" White Pinfed Labels
209 Labels Per Box

TLD-2P
2" White Pinfed Labels
1250 Labels Per Box

TLD-1P
1" White Pinfed Labels
2500 Labels Per Box

Features:

- 2500" of labels per box (209 fan-folded sheets)
- Easy way to add data to charts without taking the file apart

Customize with Colors

HCFAs

All government-approved health insurance claim forms (HCFAs) are available.

Printed in OCR (optical character recognition) red ink, most HCFAs are compatible with optical computerized scanning. This allows insurers to reduce the time and cost of processing claims and improves accuracy.

A variety of efficiency-enhancing formats are available:

- Forms for laser printers
- Peel-off address labels
- Choice of white or canary duplicates
- Optional black bar codes printed on all parts

HEALTH INSURANCE CLAIM FORM

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED CMO 5938 0008

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (ECCA) OTHER (a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1))

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTHDATE (MM / DD / YY) SEX (M / F)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE

6. PATIENT RELATIONSHIP TO INSURED (Self / Spouse / Child / Other)

7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO

11. INSURED'S DATE OF BIRTH (MM / DD / YY) SEX (M / F)

12. PATIENT'S ON AUTHORIZED PERSON'S SIGNATURE (Indicate the release of an individual 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.)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate service described below.)

14. DATE OF CURRENT ALIEN'S (First temporary or permanent) RESIDENCE (MM / DD / YY)

15. IS PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY (Specify date) (MM / DD / YY)

16. DATE OF CURRENT ALIEN'S (First temporary or permanent) RESIDENCE (MM / DD / YY)

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (MM / DD / YY)

18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM / TO)

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM / TO)

20. OUTSIDE LAB? YES / NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAL RE submission CODE

23. PRIOR AUTHORIZATION NUMBER

24. DATES OF SERVICE (A) (MM / DD / YY) (B) (MM / DD / YY) (C) (MM / DD / YY)

25. FEDERAL TAX ID NUMBER (SSN EIN)

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (Do not check this box unless you are a provider.) YES / NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE OR CREDENTIALS if each that the customer on the reverse reply to this label and are made a part thereof)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

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