GHDE

Srinivas R Panja MD

Safrin Ali Pa-C

Office Policies for Patients

APPOINTMENTS

Office visits are **by appointments only**. To ensure timely continued care, we encourage patients to schedule appointments in advance of the follow up due date. While we strive to schedule appointments appropriately, emergencies can and do occur. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

CANCELLATION OF APPOINTMENT/ NO SHOWS

If it is necessary to cancel your scheduled appointment, we require that you give us a 24 hours notice. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care. Failure to cancel an appointment will result in a **"no show" fee of $25.00**. Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.

INSURANCE

Please check with our office prior to your appointment to verify that we accept your insurance plan. It is the patient's responsibility to inform our office of any changes to insurance coverage. If you have an HMO plan, it is the patient's responsibility to obtain and maintain an active referral prior to the appointment. Failure to do so could cause delay or denial of insurance payment.

FORMS/ LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. We will be happy to complete forms and write medical letters as necessary upon your request. Because this can be time consuming, please allow 7-10 business days for completion of requested forms/letters. An **administrative fee of $25 will be required** as deemed appropriate.

REFILLS/ PHARMACY

Please inform our office of which Pharmacy you use and update us if this changes. We encourage our patients to review their medications prior to their appointments and to **request refills at the time of your visit**. If refills are requested in between follow up visits, please allow us 1-3 business days for fulfillment. If you have not been seen within the last 6 months, then an office visit will be required prior to approving refills requests. *Controlled medications will NOT be refilled without an office visit every 6 months.*

PHONE CALL

We do receive a high volume of calls. We do our best to answer all calls, however on occasion, we are busy with other patients and calls get forwarded to a voice mailbox. Please leave a message if you get our voice mail. We check messages continuously throughout the day, and will call you back within 24 hours.

By signing below, I acknowledge that I have received, reviewed, and understand the policies and procedures explained in the GHDE OFFICE POLICIES form.

Print Name: _____ Date: _____

SIGNATURE: _____ DOB: _____

GHDE Srinivas R Panja MD
Safrin Ali PA-C
REGISTRATION FORM
(Please Print)

Today's Date:	POP Name :	POP #:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Wid ☐

Patient Email:	Pharmacy Name:	Pharmacy Address:	Pharmacy Ph.no:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Cell phone no: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Cell phone no: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ MEDICARE	☐ BCBS	☐ AETNA	☐ CIGNA	☐ HUMANA

☐ MUTUAL OF OMAHA	☐ UNITED HEALTHCARE	☐ UMR	☐ FIRST HEALTH NETWORK	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Cell phone no: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

GHDE
Greater Houston
Diabetes & Endocrinology Center

18648 Mckay Dr Suite - 100
Humble, TX 77338 Fax: 713-389-5325

Srinivas R Panja MD
Safrin Ali PA-C

Tel: 713-936-2966
www.GHEndocrinology.com

920 Medical Plaza Dr Suite - 350
The Woodlands TX 77380
Fax: 281-719-8671

Due to the new laws enacted by congress, we are required to have signed this consent from prior to receiving treatment.

Do you consent to a medical examination and any procedures or tests deemed necessary by Dr. Srinivas Panja while you are in our office?

YES NO

Do you consent to the staff releasing information about appointments and or test results to someone on your list?

YES NO

Do you consent to the staff leaving messages on an answering machine or voice mail system regarding appointments and or test results?

YES NO

Do you consent to our office mailing you bills to your home?

YES NO

Please list the names of the person or persons to whom we can discuss medical information with:

NAME	RELATIONSHIP
_____	_____
_____	_____

_____

SIGNATURE: _____ Date: _____ Print Name: _____

If you wish this consent to be effective indefinitely or until you have revoked it please initial here: _____.

If not initialed you will have to do a new form every time you visit.
You may revoke this consent at any time. By revoking consent you will receive no further treatment from this office.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary**:** By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how can obtain access to this information.

As a patient, you have following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	
Contact Person	Office of Dr. Panja
Phone Number	713-936-2966

Acknowledgement of Notice of Privacy Practices

"I here acknowledge that I have received a copy of this practice's NOTICE ***OF PRIVACY PRACTICES.***
I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES should*** it be amended, modified or changed in any way."

_____
Patient or Representative Name (Please Print)

_____
Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because _____

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NEW PATIENT HISTORY FORM – PAGE 1

NAME_____

DOB _____/_____/_____

PCP/Referring Physician_____

DO YOU HAVE (OR HAVE YOU HAD) ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
DIABETES			ASTHMA		
HIGH BLOOD PRESSURE			EMPHYSEMA OR COPD		
CHOLESTEROL PROBLEM			ANEMIA		
HEART PROBLEMS			STOMACH ULCER		
STROKE			HEARTBURN		
SEIZURES			ARTHRITIS		
THYROID PROBLEMS			HIV INFECTION		
LIVER PROBLEMS			CANCER		
KIDNEY PROBLEMS			ANXIETY		
OSTEOPOROSIS			PANIC ATTACKS		
BROKEN BONES			DEPRESSION		

PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU HAVE OR ANY OTHER REASON YOU SEE A DOCTOR:

PLEASE LIST ANY <u>OPERATIONS</u> OR <u>HOSPITALIZATIONS</u> YOU HAVE HAD, WHERE THESE OCCURRED, AND THE YEAR PERFORMED:

PLEASE LIST ANY MEDICATION **ALLERGIES** OR BAD **REACTIONS** TO MEDICATIONS THAT YOU HAVE HAD:

WHAT IS YOUR MARITAL STATUS?_____
HOW MANY CHILDREN DO YOU HAVE? ___
WHAT IS YOUR OCCUPATION? _____

DO YOU SMOKE? ☐YES ☐FORMER ☐NEVER
DRINK ALCOHOL? ☐YES ☐NO

FAMILY HISTORY:

	AGE IF LIVING	AGE AT DEATH	CAUSE?
MOTHER			
FATHER			
BROTHERS			
NO. LIVING NO. DEAD			
SISTERS NO. LIVING NO. DEAD			

HAVE ANY FAMILY MEMBERS BEEN DIAGNOSED WITH THE FOLLOWING? <u>WHO HAS THIS?</u>

DIABETES	☐YES ☐ NO	
HIGH BLOOD PRESSURE	☐YES ☐ NO	
HIGH CHOLESTEROL	☐YES ☐ NO	
HEART ATTACKS AND/OR BYPASS SURGERY	☐YES ☐ NO	
STROKE	☐YES ☐ NO	
CANCER	☐YES ☐ NO	
THYROID PROBLEMS	☐YES ☐ NO	
KIDNEY STONES	☐YES ☐ NO	
OSTEOPOROSIS	☐YES ☐ NO	

<u>FOR WOMEN ONLY</u>:

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL CYCLE? _____

ARE YOUR MENSTRUAL CYCLES REGULAR? ☐YES ☐ NO

WHAT WAS THE DATE YOUR LAST MENSTRUAL CYCLE STARTED? _____

HAVE YOU GONE THROUGH MENOPAUSE?
☐NO ☐YES, AT AGE _____

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____
HOW MANY CHILDREN HAVE YOU HAD?_____
HOW MANY MISCARRIAGES HAVE YOU HAD? _____

PHYSICIAN NOTES:

REVIEWED BY: _____
DATE: _____

NEW PATIENT HISTORY FORM – PAGE 2

NAME: _____

PLEASE LIST ALL YOUR MEDICATIONS IN THE TABLE BELOW.

MEDICATION NAME	**PILL SIZE** *(HOW MANY MILLIGRAMS?)*	**TIMES TAKEN AND NUMBER OF PILLS TAKEN** *(EXAMPLE – TWO AT BREAKFAST, ONE AT DINNER)*

(PLEASE INCLUDE HORMONE MEDICATIONS, BIRTH CONTROL PILLS, HERBAL MEDICINES, VITAMINS, DIET SUPPLEMENTS, OR OVER-THE-COUNTER MEDICINES THAT YOU TAKE ON A REGULAR BASIS. IF YOU NEED MORE SPACE, PLEASE ATTACH ANOTHER PAGE.)

HAVE YOU HAD RECENT PROBLEMS WITH THE FOLLOWING?

☐Y ☐N FATIGUE
☐Y ☐N WEIGHT GAIN
☐Y ☐N WEIGHT LOSS
☐Y ☐N HEAT INTOLERANCE
☐Y ☐N COLD INTOLERANCE
☐Y ☐N POOR SLEEP
☐Y ☐N BLURRED VISION
☐Y ☐N DOUBLE VISION
☐Y ☐N HOARSENESS
☐Y ☐N SORE THROAT
☐Y ☐N CHEST PAIN
☐Y ☐N PALPITATIONS
☐Y ☐N SHORT OF BREATH
☐Y ☐N COUGH
☐Y ☐N NAUSEA
☐Y ☐N VOMITING
☐Y ☐N DIARRHEA
☐Y ☐N CONSTIPATION
☐Y ☐N FREQUENT URINATION
☐Y ☐N NIGHTTIME URINATION
☐Y ☐N LOW LIBIDO
☐Y ☐N HOT FLASHES
☐Y ☐N ABNORMAL PERIODS (WOMEN)
☐Y ☐N POOR ERECTIONS (MEN)
☐Y ☐N JOINT PAIN
☐Y ☐N MUSCLE ACHES/PAIN
☐Y ☐N MUSCLE WEAKNESS
☐Y ☐N RASH
☐Y ☐N EASY BRUISING
☐Y ☐N HEADACHE
☐Y ☐N NUMBNESS/TINGLING
☐Y ☐N DEPRESSED
☐Y ☐N ANXIOUS
☐Y ☐N FALLS

PHYSICAN NOTES:

REVIEWED BY: _____
DATE: _____

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. As such, each patient is allowed two of the following:

Cancellations less than 24 hours' notice, No Show, or arriving to your appointment more than 30 minutes late. Effective Jan 1st 2015 after the second offense office of Greater Houston Diabetes & Endocrinology Center (GHDE) reserves the right to charge a fee of $25.00 for all "No Show" s and Cancellations less than 24 hours' notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Greater Houston Diabetes & Endocrinology Center (GHDE)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical 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 below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 36 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.