

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	2c. Taxonomy Code	3. Recipient Name and Address
	2b. NPI Number	4. Recipient Medicaid ID	

5. Patient Acct. / Med Rec Num.	6. Diagnosis			
	Primary	Secondary	3rd	4th

7. Service Dates		8. Procedure Code	9. Modifier	10. Service Units	11. Medicare Billed Charges	12. Medicare Allowed Amounts
From	Thru					
13. Medicare Non-Covered Amt.	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-Insurance	18. Medicare Paid Date	19. Third Party Amount
1						
8a. NDC						
2						
8a. NDC						
3						
8a. NDC						
4						
8a. NDC						
5						
8a. NDC						
6						
8a. NDC						

I certify that the foregoing information is true, accurate, and complete and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. 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 may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted with the exception of authorized copayment.

20. Provider Signature

21. Billing Date