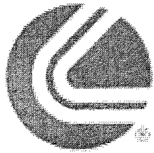

Return Completed Form and Required Documents **TO:**
Fax Number: 803-264-5149
E-Mail: www.network@companionworkgroup.com

PARTICIPATION REQUEST FORM

STEP 1: INFORMATION FROM PROVIDER
Today's Date:

Provider Type: ☐ Acute Care Hospital ☐ Ancillary Services ☐ Individual Practitioner ☐ Group
(Per license) ☐ SNF ☐ Rehab Hospital ☐ Psych Hospital ☐ Ambulance ☐ ASC ☐ Other

Specialty: ______________________________

Legal Name: ____
(Per assigned Tax ID number, i.e. as filed on annual Tax Return)

DBA: ____
If group practice, please attach roster with each practitioner's name and specialty.

Contact Name: ______________________________ **Contact Phone#:** ____________________
(Party receiving application and who will be able to provide additional information if required)

E-Mail Address ____
(Party receiving application)

E-Mail Address ____
(Party receiving contract)

Mailing Address: ____
(For Primary Practice Location)

City ______________________________ **State** ______________________ **Zip** ____________________

Billing Address (if not the same as Mailing Address): ____

City ______________________________ **State** ______________________ **Zip** ____________________

Request Form Completed by: ______________________________ **Phone#:** ____________________

Comments: ____
____

Please Attach Copy of Completed W-9; Letter assigning Tax ID number and Sample Claim Form, see attached.

STEP 2: RECEIVED COMPANIION PROPERTIES & CASUALTY (CPC) to be completed by CPC

Date Received: ______________

Date Application Sent: ______________ **By:** ______________________________________

STEP 3: FILE INFORMATION to be completed by CPC

Date Completed Application Rcvd: ______________

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID 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	

24J: Attending provider NPI.

32: Rendering location address. Must include ZIP + 4 Code.

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. BALANCE DUE

33: Billing provider information. Must include ZIP + 4 Code.

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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE

a. b.

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

33a: NPI for billing provider.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FL1

Enter the billing provider's name, address, city, state (2-character state code), ZIP+4 (no hyphen) and telephone number (include area code).

If different than FL1, enter the pay-to provider name and address or PO Box, city, state (2-character) and ZIP code (5-digit).

Enter the number assigned to the pay-to provider by the federal government for tax reporting purposes (FEIN) (include hyphen).

Enter the billing provider's NPI number.

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

TYPE 15 SRC | ION CODES 23

OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI

57

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX | 67 | A | B | C | D | E | F | G | H | 68
I | J | K | L | M | N | O | P | Q

69 ADMIT DX | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | 72 ECI | a | b | c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 Printed on Recycled Paper NUBC National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.