

**NON-COUNTY
CONTRACTED
PHYSICIANS**

DATA FORM - EMSF/CHIP/TSF UNCOMPENSATED CARE PROGRAMS

PATIENT INFORMATION *

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-1500

1. SOCIAL SECURITY NUMBER:

2. PATIENT'S NAME: _____
LAST FIRST MIDDLE INITIAL

(1) IF MINOR, PARENT/GUARDIAN: _____
LAST FIRST

3. PLACE OF BIRTH: _____
CITY STATE COUNTRY

4. MOTHER'S MAIDEN NAME: _____

5. ETHNICITY: (1) WHITE (4) NATIVE AMERICAN/ESKIMO/ALEUT (7) OTHER
 (CHECK ONE) (2) BLACK (5) HISPANIC
 (3) ASIAN/PACIFIC ISLANDER (6) FILIPINO

6. EMPLOYMENT TYPE: (0) UNEMPLOYED (3) SALES/SERVICE
 (1) FARMING/FORESTRY/FISHING (4) EXECUTIVE/ADMINISTRATIVE/MANAGER/
 (2) LABORERS/HELPERS/CRAFT/ INSPECTION/REPAIR/PRODUCTION/ TRANSPORTATION
 PROFESSIONAL/TECHNICAL/RELATED SUPPORT
 (5) OTHER

7. MONTHLY INCOME: \$ 8. FAMILY SIZE (COUNT PATIENT AS 1):

SOURCE OF INCOME: (0) NONE (3) SELF-EMPLOYED (6) OTHER, e.g., UNEMPLOYMENT/VA
 (1) GENERAL RELIEF (4) DISABILITY BENEFITS/INTEREST/DIVIDENDS/RENT/
 (2) WAGES (5) RETIRED CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

REASON (S): _____

* IF UNABLE TO OBTAIN INFORMATION FROM HOSPITAL, SUBMITTING PHYSICIAN/AGENCY MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

SIGNATURE: _____

PHYSICIAN SERVICES

19. PHYSICIAN FUND -- (CHECK ONE BOX ONLY): Use a separate Data Claim Form for each Physician Fund area below.
 (1) NON-CONTRACT EMERGENCY (3) OBSTETRICS EDD:
 (2) PEDIATRICS (4) BEYOND 48 HOURS
 Must provide following info on intial ER encounter:
 Date: _____ Provider: _____

20. SERVICE SETTING: (1) INPATIENT
 (2) EMERGENCY DEPARTMENT
 (3) OUTPATIENT/OFFICE VISIT (CHECK ONE): a. PRIMARY CARE b. SPECIALTY CARE

21. PHYSICIAN'S NAME: _____ STATE LICENSE NO: _____

22. PAYEE NAME: _____ PAYEE TAX ID#: _____
 PAYEE ADDRESS: _____

23. DATE BILLED EMSF: CHARGES: \$

FOR QUESTIONS REGARDING CLAIM: _____

24. CONTACT PERSON _____ TELEPHONE NO: () _____