CURE COUNSELING & ASSESSMENT TRAINING CENTRE

2594 Highway 34 East #B
Newnan, GA 30265
(770) 252-3760 office@curecounseling.com

Children's Intake & Bio-Pyschosocial Assessment

Child's Name: _____ Date: _____

Child's age: _____ Date of Birth: ____ / ____ / _____ Sex (circle one): Male Female

Address: _____
Street

_____ _____ _____
City State Zip

Parents / Stepparents
Mother's name: _____ Age: _____ Education: _____ Occupation: _____

Father's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Marital status of parents: _____ If parents are separated/divorced, how old was child at time of separation? _____

With whom does the child live? _____

Custody: ❑Lives in one home with both legal parents. ❑Mother has physical custody.
❑Father has physical custody. ❑Physical custody is shared. ❑Other: _____

List all people living in household:

Name	Age	Relationship to child

If any brothers or sisters are living outside the home, list their names and ages:

_____

_____

If any brothers / sisters are deceased, please give name and year: _____

FAMILY INFORMATION:
Place of birth: _____

Child's Race: ❑African-American ❑Caucasian ❑Native American ❑Hispanic ❑Asian ❑Latino ❑Other (specify) _____

Was the child adopted? ❑Yes ❑No If yes, at what age? _____ From where? _____

Has the child ever been placed outside of the home? ❑Yes ❑No If yes, where? _____

In how many residences has the child lived since birth? _____

Has the child been physically or sexually abused, assaulted or molested? ❑Yes ❑No ❑Don't know
If yes, specify by whom and when: _____

Have the child's parents or any other family members had any mental health or emotional problems?
❑Yes ❑No If yes, describe: _____

PRESENTING PROBLEM:
Briefly describe your child's current difficulties: _____

_____

_____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Has the child received evaluation or treatment for the current problem or similar problems? Yes ___ No ___

If yes, when and with whom? _____

Is the child on any medication at this time? Yes ____ No ____

If yes, please note kind of medication: _____

How do you want your child's situation to be different after coming here? _____

_____

SOCIAL AND BEHAVIOR CHECKLIST
Place a check next to any behavior or problem that your child currently exhibits.

____ Has difficulty with speech
____ Has difficulty with hearing
____ Has difficulty with language
____ Has difficulty with vision
____ Has difficulty with coordination
____ Prefers to be alone
____ Does not get along well with other children
____ Is aggressive
____ Is shy or timid
____ Has poor bowel control (soils self)
____ Is much too active
____ Is more interested in things (objects) than in people
____ Engages in behavior that could be dangerous to self (describe) _____

____ Has frequent tantrums
____ Has frequent nightmares
____ Has trouble sleeping (describe) _____
____ Has blank staring spells
____ Rocks back and forth
____ Bangs head
____ Holds breath
____ Eats poorly
____ Is stubborn

Describe child's relationship with his / her:

Father _____

Mother _____

Sibling(s)_____

Step parent(s) _____

OTHER INTERPERSONAL RELATIONSHIPS:
How do you describe the child's friendships:

❑No Friends ❑Only Acquaintances ❑Both acquaintances and close friends

How many close friends? _____

Place a check next to any behavior or problem that your child currently exhibits.

Check		Check	
_____	Has special fears, habits, or mannerisms (describe) _____	_____	Is impulsive
_____	Show daredevil behavior	_____	Sucks thumb
_____	Gives up easily	_____	Is slow to learn
_____	Wets bed	_____	Other (describe): _____
			_____
			_____

EDUCATIONAL HISTORY

School: _____ Grade: _____

Place a check next to any educational problem that your child currently exhibits:

Check		Check	
_____	Has difficulty with reading	_____	Has difficulty with other subjects (please list) _____
_____	Has difficulty with arithmetic		
_____	Has difficulty with spelling		_____
_____	Has difficulty with writing	_____	Does not like school

Is your child in a special education class? Yes _____ No _____
If yes, what type of class? _____

Has your child been held back in a grade? Yes _____ No _____
If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____
If yes, please describe: _____

Has your child ever been suspended or expelled? Yes _____ No _____
If yes, please describe: _____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes ____ No ____ If yes, what kind? _____

During pregnancy, did mother smoke? Yes ____ No ____ If yes, how many cigarettes each day? ____

During pregnancy, did mother drink alcoholic beverages? Yes ____ No ____ If yes, what did she drink?
_____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? Yes ____ No ____ If yes, what kind? _____

Were forceps used during delivery? Yes ____ No ____

Was a Cesarean section performed? Yes ____ No ____ If yes, for what reason? _____

Was the child premature? Yes ____ No ____ If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes ____ No ____ If yes, please describe: _____
_____

Were there any feeding problems? Yes ____ No ____ If yes, please describe: _____
_____

Were there any sleeping problems? Yes ____ No ____ If yes, please describe: _____
_____

As an infant, was the child quiet? Yes ____ No ____

As an infant, did the child like to be held? Yes ____ No ____

Were there any special problems in the growth and development of the child during the first few years?
Yes ____ No ____ If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked alone	_____	Fed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		

CURRENT HEALTH INFORMATION:
Describe child's health generally: ❑Good ❑Fair ❑Poor Is the child sexually active? ❑No ❑Yes

List any health problems the child has had:_____

_____

_____

Does the child have:

Current immunizations ❑No ❑Yes Which are needed? _____

Any allergies ❑No ❑Yes Specify _____

Nutritional problems ❑No ❑Yes Specify _____

Appetite problems ❑No ❑Yes Specify _____

Sleep problems ❑No ❑Yes Specify _____

A disability or handicap ❑No ❑Yes Specify _____

Contagious or other diseases ❑No ❑Yes Specify _____

Any accidents / injuries ❑No ❑Yes Specify _____

Dental, vision or hearing problems ❑No ❑Yes Specify _____

Any hospitalizations ❑No ❑Yes Specify _____

Physician: _____
Name City

Date of last contact: ____ / ____ / ____ Reason for last contact: _____

SUBSTANCE USE / ABUSE:
Please complete the chart below

Category of Drug	Has child ever used?	Currently using?	Age at first use	How often does child use?	How taken?	How much?	Use last 48 hours?	Withdrawal symptoms
Alcohol	❑No ❑Yes	❑No ❑Yes						
Stimulant	❑No ❑Yes	❑No ❑Yes						
Cocaine	❑No ❑Yes	❑No ❑Yes						
Tranquilizer	❑No ❑Yes	❑No ❑Yes						
Barbituate	❑No ❑Yes	❑No ❑Yes						
Marijuana	❑No ❑Yes	❑No ❑Yes						
Opiod	❑No ❑Yes	❑No ❑Yes						
Hallucinogen	❑No ❑Yes	❑No ❑Yes						
Prescribed	❑No ❑Yes	❑No ❑Yes						
Nictine	❑No ❑Yes	❑No ❑Yes						
Caffeine	❑No ❑Yes	❑No ❑Yes						
Other	❑No ❑Yes	❑No ❑Yes						

FAMILY MEDICAL HISTORY:
Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

Check	Condition	Relationship to child	Check	Condition	Relationship to child
_____	Alcoholism	_____	_____	Depression	_____
_____	Cancer	_____	_____	Learning disability	_____
_____	Diabetes	_____	_____	ADHD	_____
_____	Heart trouble	_____	_____	Mental Retardation	_____
_____	Bipolar Disorder	_____	_____	Other	_____
_____	Anxiety Disorder	_____			

RELIGION / SPIRITUALITY:

Religion: ❑Protestant ❑Catholic ❑Buddhist ❑Hindu ❑Jewish ❑Muslim ❑Atheist ❑Agnostic ❑Other: _____

LEGAL INFORMATION:

Has the child ever:
- Had difficulty or contact with police? ❑Yes ❑No
- Appeared in juvenile conference? ❑Yes ❑No
- Been on probation? ❑Yes ❑No

Please explain: _____

_____

OTHER INFORMATION:

What are your child's favorite activities?

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

What activities would your child like to engage in more often than he/she does at present?

1. _____ 2. _____

What activities does your child like least?

1. _____ 2. _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check	Disciplinary technique	Check	Disciplinary technique
_____	Ignore problem behavior	_____	Tell child to sit on chair
_____	Scold child	_____	Send child to his or her room
_____	Spank child	_____	Take away some activity or food
_____	Threaten child	_____	Other technique (describe) _____
_____	Reason with child	_____	Redirect child's interest
_____	Don't use any technique		

Which disciplinary techniques are usually effective? _____

_____

With what type of problem(s)? _____

_____

Which disciplinary techniques are usually ineffective? _____

_____

With what type of problem(s)? _____

_____

What have you found to be the most satisfactory ways of helping your child? _____

_____

What are your child's assets or strengths? _____

_____

PREVIOUS COUNSELING / PSYCHOTHERAPY:

Has your child ever been in counseling / therapy before? ❑No ❑Yes

Name of Provider Clinic Year Diagnosis / Problem

_____

_____

_____

Has your child been prescribed psychotropic medication? ❑No ❑Yes

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Reason: _____

Other medications currently prescribed:

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Reason: _____

Check if applicable: ❑Inpatient ❑Day Treatment ❑Substance Abuse Program
❑Psychological Testing ❑Partial Hospitalization

Explain any of the above: _____

_____

Has the child ever:

Made a suicide attempt: ❑No ❑Yes If yes, when? _____

_____

Expressed homicidal thoughts: ❑No ❑Yes Describe _____

_____

Had episodes of explosive anger: ❑No ❑Yes Describe _____

_____

Is the child currently expressing homicidal / suicidal feelings? ❑No ❑Yes

* *

Signature of Informant _____Date _____

Relationship to client _____

CURE COUNSELING & ASSESSMENT TRAINING CENTRE
SNAP ASSESSMENT

CLIENT: **DOB:** **DATE:**

STRENGTHS

What personal qualities do you have which we can build upon in treatment?

- ☐ Open minded
- ☐ Friendly
- ☐ Creative
- ☐ Good Listener
- ☐ Quick Learner
- ☐ Good Grooming
- ☐ Organized
- ☐ Takes personal responsibility
- ☐ Strong personal or spiritual values
- ☐ Independent
- ☐ Assertive
- ☐ Hard Worker
- ☐ Able to learn from my experiences
- ☐ Can collaborate/ work with others
- ☐ Good Problem Solver
- ☐ Good Decision Maker
- ☐ Dependable
- ☐ Motivation
- ☐ Good health
- ☐ Other (Please List)

_____

_____

_____

NEEDS

What would help you achieve your goals? Please, check your most important needs.

(Prioritize your top three)

- ☐ Increase my knowledge of resources that provide me with support
- ☐ Referral to resources for job training or education
- ☐ Access to medical care for health related concerns
- ☐ Staying in a sober environment to help me not use drugs and or alcohol
- ☐ Gain more knowledge and understanding about:
  - ☐ My mental health diagnosis
  - ☐ My medication(s)
  - ☐ My symptoms / behaviors related to my mental health diagnosis
- ☐ Get help to stop smoking
- ☐ Learn how to empower myself to take a more active role in my treatment
- ☐ Increasing effective communication skills to improve my relationships with others
- ☐ Learn how to talk about my concerns/issues/feelings
- ☐ Practice my coping skills in a safe environment
- ☐ Learn more about effective coping skills related to:
  - ☐ Improving my sleep
  - ☐ Reducing anxiety and using relaxation
  - ☐ Managing my depression
  - ☐ Leisure skills
  - ☐ Organizing daily activities
  - ☐ Managing anger
  - ☐ Mood Regulation
  - ☐ Improving reality-based thinking
  - ☐ Eating Healthy
- ☐ Other (Please List)

_____

_____

Abilities

What skills do you possess?

- ☐ Basic ability to read and write
- ☐ Computer knowledge and skills
- ☐ Ability to work effectively with others
- ☐ Knowledge or tools that I use to help me manage my emotions
- ☐ Ability to have positive relationships with others
- ☐ Ability to make healthy decisions about my life
- ☐ Job Skills _____
- ☐ Education / Training_____
- ☐ Leisure Skills_____
- ☐ Ability to manage my time and structure my daily activities
- ☐ Other (Please List)

Preferences

How do you want your treatment?

- ☐ I prefer my family or friends to be involved in my treatment
- ☐ I would like to have a family meeting

I learn new information better:

- ☐ Face to face
- ☐ Hands on instruction and practice
- ☐ Reading written material
  - ☐ Alone
  - ☐ In discussion with others
- ☐ Sharing information in a group of my peers

☐ I would like to live:

- ☐ Independently, on my own
- ☐ Independently, with community support
- ☐ With others
- ☐ Other ideas I have about my living situation (Please List)

_____

_____

_____

☐ I am interested in learning more about

- ☐ Outpatient programming
- ☐ Community resources
- ☐ Other areas of interest (Please List)

_____

_____

_____

_____

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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? PLACE (State) YES NO

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 Text DATE /2023

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 Text

PATIENT AND INSURED 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	

PHYSICIAN OR SUPPLIER INFORMATION

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 TRICARE 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 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 TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE 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, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE 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, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, 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; 38 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 TRICARE 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 TRICARE/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 TRICARE.

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 0938-1197. 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, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.