HOUSE BILL No. 5272

October 17, 1991, Introduced by Reps. Stallworth, Wallace, DeMars, Dobronski, Joe Young, Jr., Baade, Kilpatrick, Gire, Olshove, Kosteva, Gubow, Willis Bullard, London, Hoffman, Dolan, Middleton, Dalman, Brackenridge, Profit and Barns and referred to the Committee on Public Health.

A bill to amend Act No. 368 of the Public Acts of 1978, entitled as amended

"Public health code,"

as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding section 21055a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding section 21055a to read as follows:

SEC. 21055A. (1) BEGINNING OCTOBER 1, 1992 AND CONTINUING UNTIL RULES ARE PROMULGATED UNDER SECTION 2240 OF THE INSURANCE CODE OF 1956, ACT NO. 218 OF THE PUBLIC ACTS OF 1956, BEING SECTION 500.2240 OF THE MICHIGAN COMPILED LAWS, A HEALTH

MAINTENANCE ORGANIZATION SHALL REQUIRE ONLY THE FOLLOWING STANDARD MEDICAL CLAIM FORM BE USED BEFORE A CLAIM IS PAID:

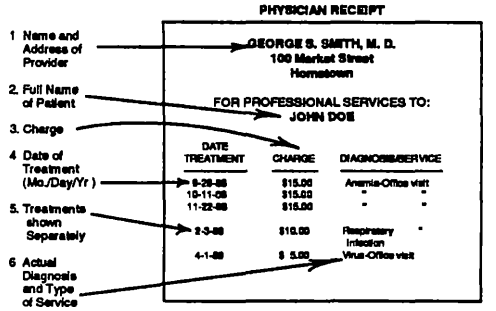
MEDICAL CLAIM FORM

INSTRUCTIONS FOR FILING A CLAIM (PLEASE TYPE OR PRINT)

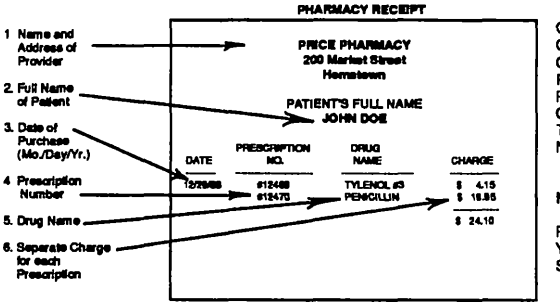
- FOR EACH ELIGIBLE FAMILY MEMBER, DEPENDENT OR SPOUSE SEPARATE ALL ITEMIZED BILL(S), RECEIPT(S), COPIES OF EXPLANATION OF BENEFITS FORMS OR CHECK VOUCHERS.
- COMPLETE A SEPARATE CLAIM FORM FOR EACH ELIGIBLE MEMBER.
- ATTACH EACH MEMBER'S ITEMIZED BILL(S) OR RECEIPT(S) TO HIS/HER COMPLETED CLAIM FORM(S). ALL COMPUTERIZED RECEIPTS SUBMITTED MUST INCLUDE THE PROVIDER SIGNATURE AND PROVIDER CODE.
- IF APPLICABLE, ATTACH COPIES OF YOUR EXPLANATION OF MEDICARE BENEFITS FORM OR MEDICARE VOUCHER.
- SAVE COPIES OF ALL ITEMS SUBMITTED.
- CLAIM FORM SHOULD BE SIGNED BY THE (INSERT INSURED OR SUBSCRIBER).

EXAMPLES OF PROPERLY ITEMIZED RECEIPTS

PHYSICIAN RECEIPT



PHARMACY RECEIPT



CASH REGISTER RECEIPTS, CANCELLED CHECKS, MONEY ORDER RECEIPTS, UN-SIGNED COMPUTERIZED RECEIPTS OR STATEMENTS AND PERSONAL ITEMIZATIONS **ARE NOT** ACCEPTABLE AND IF SUBMITTED BECOME THE PROPERTY OF (INSERT COMPANY NAME).

NOTE:

FOR BEST SERVICE, PLEASE SUBMIT YOUR MEDICAL CLAIMS TO US AS SERVICES OCCUR.

(INSERT INSURED OR SUBSCRIBER) LAST NAME | FIRST NAME

STREET ADDRESS | CITY

STATE | ZIP CODE | (INSERT INSURED'S OR SUBSCRIBER'S) CONTRACT NUMBER ▶ | GROUP NO. ▶

PATIENT LAST NAME | FIRST NAME | PATIENT'S DATE OF BIRTH ▶ MO. DAY YR.

PATIENT'S RELATIONSHIP TO (INSERT INSURED OR SUBSCRIBER) ☐ SELF ☐ SPOUSE ☐ DEPENDENT | PATIENT SEX ☐ M ☐ F | WORKER'S COMP. ☐ YES ☐ NO | WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO | ACCIDENT ☐ YES ☐ NO | IF YES, GIVE DATE OF ACCIDENT ▶ MO. DAY YR.

SPOUSE'S SOCIAL SECURITY NUMBER ▶ | SPOUSE'S DATE OF BIRTH ▶ MO. DAY YR. | (INSERT INSURED'S OR SUBSCRIBER'S) DATE OF BIRTH ▶ MO. DAY YR

OTHER MEDICAL COVERAGE ☐ YES ☐ NO | NAME OF OTHER COMPANY | FOR COMPANY USE ONLY

STREET ADDRESS AND CITY OF OTHER COMPANY | STATE | ZIP CODE

CERTIFICATION STATEMENT

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THE ATTACHED MATERIAL IS CORRECT AND UNALTERED AND THAT THE EXPENSES WERE INCURRED BY THE ABOVE NAMED PATIENT. I UNDERSTAND ALL MATERIAL SUBMITTED BECOMES THE PROPERTY OF (INSERT COMPANY NAME) AND MAY NOT BE RETURNED. I REALIZE FALSE RECEIPTS OR FRAUDULENT ALTERATIONS OF THESE MATERIALS WILL RESULT IN CIVIL OR CRIMINAL PROSECUTION. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS OR REVIEW THIS CLAIM.

SIGNATURE

DATE | TELEPHONE NO. ( )

CLAIM NUMBER (FOR COMPANY USE ONLY)

YOUR RIGHT TO CONFIDENTIALITY

WE WILL NOT RELEASE ANY INFORMATION ABOUT YOU EXCEPT: 1) WHEN YOU ASK US IN WRITING, OR 2) WHEN RELEASE (TO ANOTHER INSURANCE COMPANY FOR EXAMPLE) IS NECESSARY TO PROCESS OR REVIEW A CLAIM. WE WILL TELL YOU WHICH INFORMATION WE RELEASED TO WHOM, IF YOU REQUEST IT.

MAIL TO: (INSERT COMPANY'S NAME AND ADDRESS OF COMPANY OR REGIONAL CLAIMS CENTER.)

(2) UPON A SUBSCRIBER'S REQUEST, A HEALTH MAINTENANCE ORGANIZATION SHALL RELEASE TO THE SUBSCRIBER A COPY OF THE SUBSCRIBER'S STANDARD MEDICAL CLAIM FORM WITH INFORMATION EXPLAINING THE CODING FOR THE PROCEDURE OR SERVICE PERFORMED.