PATIENT CASE HISTORY

CONTACT INFORMATION

Name:______________________________ DOB: ____/____/________

Address:______________________________ City:________________

State:________ Zip:______________ Email:______________________

Occupation:____________________ SS#:______________ Age:__________

Phone Number:____________________ Cell Phone:____________________

Of Children:______________ Marital Status (circle one): Married / Single / Widowed / Divorced

Referred By?____________________ Phone Number:____________________

Emergency Contact:

Name: ______________________________ Relationship:________________

Phone Number: ______________________

HEALTH INFORMATION

Have you received previous Chiropractic Care? YES or NO Physical therapy Care? YES or NO

What is your major complaint?____

____

How long have you had this condition? ______________ Has this happened in the past? YES or NO

Is your condition getting progressively worse? YES / NO / CONSTANT/ ON & OFF

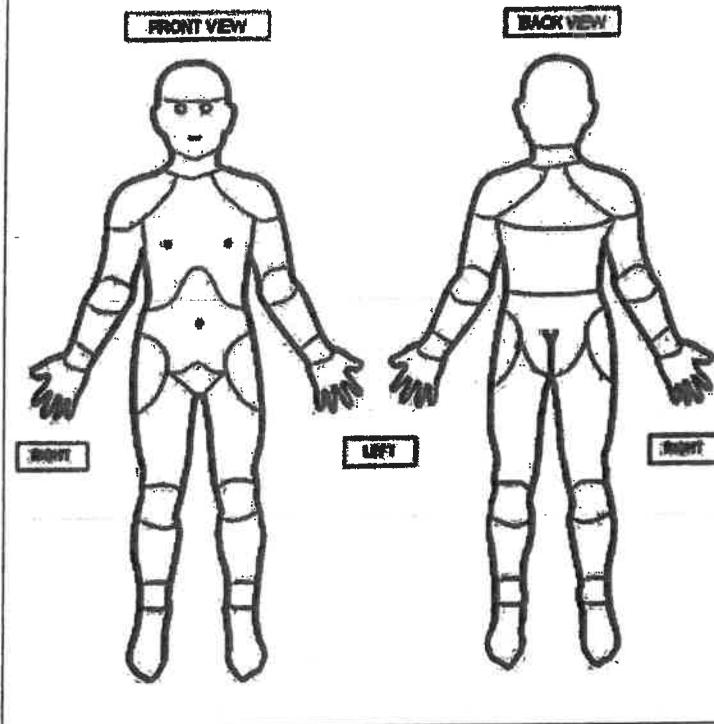
Is this condition interfering with your (CIRCLE ALL THAT APPLIES)? WORK / SLEEP/ DAILY ACTIVITY

Does anyone in your family have the same condition? YES or NO PLEASE LIST ____________________

Has any another doctor treated this condition? ______________________________

Date of last physical exam: _____/_____/_____

Please mark pain in areas below:



Have you ever suffered from the following conditions? Check if applicable.

☐ Stroke	☐ High Blood Pressure
☐ Cancer	☐ Visual Impaired
☐ Heart Disease	☐ Hearing Impaired
☐ Diabetes	☐ Latex Allergy
☐ Arthritis	☐ Digestive Disorders
☐ HIV/AIDS	☐ Pacemaker
☐ Osteoporosis	☐ Scoliosis
☐ Hepatitis	☐ Fibromyalgia
☐ Tuberculosis	☐ Tuberculosis
☐ Asthma	☐ Headaches
☐ Anxiety	☐ Dizziness
☐ Sinus Trouble	☐ Backaches
☐ Neck Pain	☐ Allergies:____________
☐ Epilepsy	☐ Other:____________

Please list any surgical operations and the year they were performed:______________________________

____

Please circle the drug you are currently taking: Nerve Pills • Pain Killers • Muscle Relaxers • Pep Pills

Tranquilizers • Insulin • Birth Control Pills • Other:______________________________

Age of Mattress: ____________ Is it comfortable? ☐ Yes ☐ No

Do you wear any of the following? (circle applicable): Heel lifts • Inner soles • Arch Support

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Have you ever been in an auto accident? If yes, please describe:______________________________

____

Have you had any other personal injury, job related injury, or accident? If yes, please describe:____________

____

Primary Insurance Company:

Insurance Company Name:______________________________ **Insurance Phone #:**________________________

Member ID:______________________________ **Group #:**____________________ **Policy/Plan #:**_______________

Policy Holder:____

Are you covered by Medicare? ☐ **Yes** ☐ **No**

Insurance Policy #:______________________________________

Payment Authorization: (initials required for all 3 statements)

_________ *initals* **Assignment of insurance Benefits** I authorize that the payment of my insurance benefits be made directly to this office for all services delivered; if I am paid directly I will promptly pay this office all monies paid to me

_________ *initals* **Guarantee of Payment** I understand that all payments designated as 'the patient's responsibility' such as co-insurance and deductible are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date. Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for Payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not exceed 50%, court costs, attorney fees & interest fees accrued with the collection of this account.

_________ *initals* **Certification of Information** I certify that the information I have provided this office for payment including by not limited to, related accidents, illnesses or other insurers is accurate and truthful.

I attest, to the best of my knowledge, the above information is accurate and true.

____

Print Name

____

Signature

______/_____/__________

Date

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Saddle Brook Chiropractic and Physical Therapy's Legal Duty It is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow information practices that are described herein.

Uses and Disclosures of Health Information Saddle Brook Chiropractic & Physical Therapy use your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Saddle Brook Chiropractic and Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Saddle Brook Chiropractic and Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Saddle Brook Chiropractic and Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights you have the right to review and obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Saddle Brook Chiropractic and Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints If you are concerned that Saddle Brook Chiropractic and Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

Saddle Brook Chiropractic and Physical Therapy, 380 N. Midland Ave, Saddle Brook, NJ, 07633 (201) 880 - 7077

LATE CANCELLATION POLICY

We feel that the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments and ask that you give us the same courtesy. We understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment. ***Please see our NO -SHOW/ CANCELLATION FEES below.***

If you are unable to keep your schedule appointment, we require a **24 hour notice (1 full business day)** so that we may accommodate the Physical Therapy/Chiropractic needs of another patient. If an appointment isn't cancelled within 24 hours of the reserved appointment time or a NO-SHOW occurs, **Saddle Brook Chiropractic & Physical Therapy *WILL* charge the patient a cancellation/no-show fee.**

Physical Therapy/Chiropractic: ***Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In the event of a late cancellation/no-show, the patient WILL be charged a $50 fee.***

Thank you!

____
Print Name

____
Signature

_____/_____/__________
Date

CARDHOLDER NAME (AS SHOWN ON CARD): ______________________________

CARD NUMBER:_________/_________/_________/_________ **CVC CODE** ______________

EXPIRATION DATE (MM/YY) _______/_______ **ZIP CODE** ______________

OFFICE POLICY REGARDING BLUE CROSS BLUE SHIELD CHECKS

Dear Patients,

This letter is to inform you that you will be directly receiving checks from your insurance carrier (Blue Cross Blue Shield) for treatments that you have received in our office. It is your responsibility that you forward these checks and any other correspondence that is included with your checks into the office. In the event that you withhold such checks, you are ultimately ***responsible*** for the amount on these checks, as well as the balance of your account. If you do not comply, you are subject to legal ramification. By signing this letter you Agree and acknowledge the terms stated above.

____

Print Name

____

Signature

______/______/____________

Date

New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act ("Act")

Disclosure and Acknowledgement Form

Saddle Brook Chiropractic and Physical Therapy / Atlantic Wellness Chiropractic P.C, hereby notifies you of the follow:

I. Provider is in-network with respect to the following health benefits plans: **None**

II. Provider is out-of-network with respect to all health benefits plans **not** listed above

III. You have the right to request for the Provider the amount or estimated amount that Provider will bill you for the services available upon your request.

IV. You have the right to request that Provider provide you, in writing, with a list of services and CPT Codes associated with those services, absent of any unforeseen medical circumstance which may arise during the course of your treatment, as well as the amount or estimated amount that Provider will bill you for such services.

V. You are aware that, with respect to Provider, who is out-of-network with your benefit plan:

   a. You will have financially responsibility applicable to the health care services provided by the Provider in excess of your co-payment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plans.

   b. You should contact your carrier for further additional information on those costs.

VI. The receipt an acknowledgement of this disclosure shall not waive or otherwise affect any protection you may have under existing statutes or regulations regarding in-network health benefits plan coverage available to you or created under the Act.

VII. If between the times you were notified of the Provider's network status and the time of your procedure, the network status of Provider's changed, then Provider shall promptly notify you of the same.

New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act ("Act")

Disclosure and Acknowledgement Form

William Thimmel Chiropractic, LLC hereby notifies you of the follow:

I. Provider is in-network with respect to the following health benefits plans: **NONE**

II. Provider is out-of-network with respect to all health benefits plans **not** listed above.

III. You have the right to request for the Provider the amount or estimated amount that Provider will bill you for the services available upon your request.

IV. You have the right to request that Provider provide you, in writing, with a list of services and CPT Codes associated with those services, absent of any unforeseen medical circumstance which may arise during the course of your treatment, as well as the amount or estimated amount that Provider will bill you for such services.

V. You are aware that, with respect to Provider, who is out-of-network with your benefit plan:

   a. You will have financially responsibility applicable to the health care services provided by the Provider in excess of your co-payment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plans.

   b. You should contact your carrier for further additional information on those costs.

VI. The receipt an acknowledgement of this disclosure shall not waive or otherwise affect any protection you may have under existing statutes or regulations regarding in-network health benefits plan coverage available to you or created under the Act.

VII. If between the times you were notified of the Provider's network status and the time of your procedure, the network status of Provider's changed, then Provider shall promptly notify you of the same.

DISCLOSURE AGREEMENT

I hereby acknowledge that, prior to the scheduling of my appointment; I have received the foregoing disclosures. I have read the foregoing, Understanding its contents, and have had the opportunity to ask questions regarding the same, as well as consult with my health benefits plan in connection with the disclosures provides in this document. Being fully aware of the out-of-network/in-network status of the provider, I hereby knowingly, voluntarily, and specifically select provider for the performance of services/my procedure and related ancillary services. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures. I am not being coerced to sign the disclosure, and do so upon my own free will.

____

Print Name

____

Signature

______/_____/________

Date

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? ☐ YES ☐ NO — PLACE (State)

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 ____________ 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 ____________

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 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. 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	

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. — b.

33. BILLING PROVIDER INFO & PH # ( )

a. — b.

PHYSICIAN OR SUPPLIER INFORMATION

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.