INSTRUCTIONS FOR WSHIP HEALTH INSURANCE CLAIM FORM

The following fields are mandatory fields. They must be submitted with complete information or the claim cannot be processed.

1a. Insured’s ID number – This is the number that starts with M210 and is printed on the front of your WSHIP ID card.
2. Patient’s Name
3. Patient’s Birth Date
5. Patient’s Address, City, State and Zip Code
10. If services provided were related to an Auto Accident or Other Accident, please indicate that information. If not related to any type of accident, leave this field blank.
11. Insured’s Policy Group - BMI210
11c. Insurance Plan Name – WSHIP
11d. If you have another health insurance plan in addition to WSHIP, please check “yes”. Indicate the name of that insurance plan in 9d and include an explanation of benefits which shows if that plan paid benefits for these services provided for you.
21. Diagnosis of Illness or Injury – This is information that must be provided by the doctor or facility which provided medical services to you. The diagnosis code is at least 3 digits.
24a. Dates of Service – this is the date that you received the medical services.
24b. Place of Service –
   11 – Office
   12 – Home
   21 – Inpatient Hospital
   22 – Outpatient Hospital
   23 – Emergency Room – Hospital
   53 – Community Mental Health Center
24d. Procedure or CPT Code – This is information that must be provided by the doctor or facility which provided medical services to you. The procedure code is a 5 digit code.
24e. If the medical procedure for line 1 is a result of diagnosis code 1, then enter a 1 in this field. If it is a result of diagnosis code 1 & 2, then enter 1,2 in the field. If it is a result of diagnosis code 2, then enter 2 in this field.
24f. Charges for the medical service provided.
24g. Days or Units
25. Federal Tax ID number of the provider.
28. Total Charge – This is the total of all charges entered on this page.
29. Amount Paid – If you have paid for these services, please enter the amount you have paid in this field.
30. Balance Due
31. Signature of physician or licensed person who provided services
32. Name and address of facility where services were received.
33. Physician’s or supplier’s billing name, address, zip code & phone number.

SUBMIT CLAIMS TO ADDRESS AT THE TOP OF THE CLAIM FORM