

DO NOT WRITE IN THE SPACE BELOW

FOR MMO USE ONLY

MEDICARE		MEDICAID		CHAMPUS		CHAMPVA		GROUP		FECA		OTHER					
(Medicare #)		(Medicaid #)		(Sponsor's SSN)		(VA File #)		(SSN or IL)		(SSN)		(ID)					
<b>NOT REQUIRED BY MMO</b>												1a. INSURED'S ID NUMBER					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (Street No.)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (Street No.) <input type="checkbox"/> check here if new address.								
CITY			STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE					
ZIP CODE			TELEPHONE (Include Area Code) ( )			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (INCLUDE AREA CODE) ( )					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO ( ) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR NUMBER RECIPROcity N								
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						SEX M <input type="checkbox"/> F <input type="checkbox"/>			c. INSURANCE PLAN NAME OR PROGRAM NAME								
c. EMPLOYER'S NAME OR SCHOOL NAME						10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.								
d. INSURANCE PLAN NAME OR PROGRAM NAME						12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. 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. <b>NOT REQUIRED BY MMO</b> SIGNED _____								
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. ID NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			\$ CHARGES								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____						22. MEDICAID RESUBMISSION CODE <b>NOT REQUIRED BY MMO</b>			23. PRIOR AUTHORIZATION NUMBER <b>NOT REQUIRED BY MMO</b>								
24. A		B		C		D		E		F		G		J		K	
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		COB		RESERVED FOR LOCAL USE	
1																	
2																	
3																	
4																	
5																	
6																	
25. FEDERAL TAX ID NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$			29. AMOUNT PAID \$		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the services were rendered by me or under my direct supervision.) SIGNED _____ DATE _____						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S/ SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					



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- $$\begin{aligned}
 \frac{d}{dt} \left( \frac{1}{2} \sum_{i=1}^n \dot{x}_i^2 \right) &= \sum_{i=1}^n \dot{x}_i \ddot{x}_i \\
 &= \sum_{i=1}^n \dot{x}_i \left( -\frac{\partial V}{\partial x_i} \right) \\
 &= - \sum_{i=1}^n \dot{x}_i \frac{\partial V}{\partial x_i} \\
 &= - \frac{dV}{dt}
 \end{aligned}$$

2017年12月26日 星期三 晴