Completion	**Item**	**Item Explanation and Instructions**
Optional	**7.**	**Provider City, State, ZIP** - Enter city, state and ZIP code of provider address. See Item 6 above.
Revised Effective October 2018	**8.**	**Service Sections** – The form provides five service sections to list the specific items for which reimbursement is being requested. These service sections can be used to bill up to five items for the same patient. Claims with an attachment may only identify one date of service. At least one service section must be completed, as follows:
Required		**Recipient Name (First, MI, Last)** - Enter the patient's name. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required		**Recipient No.** - Enter the nine digit number assigned to the individual. Do not use punctuation or spaces. Do not use the Case Identification Number.
Optional		**Birth date** - Enter the month, day and year of birth of the patient. Use the MMDDYY format.
Conditionally Required		**Accident/Injury** - When applicable, enter one of the following codes to indicate the nature of any accident or injury that necessitated the patient's need for the medical equipment or supplies: 1 - A work-related accident or illness 2 - A motor vehicle accident 3 - Participation in an organized sport or school activity 4 - An act of violence (non-accidental) 5 - An unspecified accident
Not Required		Healthy Kids – Leave Blank