

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
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 SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. PATIENT STATUS
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)
a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT? PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT?
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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.
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 \_\_\_\_\_ DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #

Table with 10 columns (A-J) and 6 rows for service details.

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ( )

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_ a. NPI b. NPI

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION