

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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 M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY STATE 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? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input type="checkbox"/> MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 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.																																							
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 _____																																							
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER																																							
24. A. DATE(S) OF SERVICE From <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> To <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> B. PLACE OF SERVICE <input type="checkbox"/> C. EMG <input type="checkbox"/> D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS <input type="checkbox"/> MODIFIER <input type="checkbox"/> E. DIAGNOSIS POINTER <input type="checkbox"/>										F. \$ CHARGES <input type="checkbox"/>										G. DAYS OR UNITS <input type="checkbox"/>										H. EPSDI Family Plan <input type="checkbox"/>										I. ID. QUAL. <input type="checkbox"/>										J. RENDERING PROVIDER ID. # <input type="checkbox"/>									
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN EIN <input type="checkbox"/>										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <input type="checkbox"/>										29. AMOUNT PAID \$ <input type="checkbox"/>										30. BALANCE DUE \$ <input type="checkbox"/>																			
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. _____ b. _____										a. _____ b. _____																																							