

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX
MM DD YY M F

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

CITY STATE 8. PATIENT STATUS
Single Married Other

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)

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. YES NO

b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT? PLACE (State)
MM DD YY M F

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT?
YES NO

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE

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.

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
MM DD YY MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM TO

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES
YES NO

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.

1. 3. 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 6 rows and 10 columns for service details: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL., J. RENDERING PROVIDER ID. #

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 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