



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)						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 (No., Street)											
CITY				STATE		8. RESERVED FOR NUCC USE						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:				11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY						SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____						b. OTHER CLAIM ID (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>						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 _____						SIGNED _____											

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____						15. OTHER DATE MM DD YY QUAL: _____						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
17b. NPI _____						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____						A. _____ B. _____ C. _____ D. _____						22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
E. _____ F. _____ G. _____ H. _____						I. _____ J. _____ K. _____ L. _____						23. PRIOR AUTHORIZATION NUMBER _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/CS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1																					
2																					
3																					
4																					
5																					
6																					

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER				SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. Rsvd for NUCC Use																	
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. _____				a. NPI _____				b. _____			