

HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (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 SEX MM DD YY M F									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other									
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. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous)									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT?									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED DATE										a. INSURED'S DATE OF BIRTH SEX MM DD YY M F									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.										b. OTHER CLAIM ID (Designated by NUCC)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
A. B. C. D. E. F. G. H. I. J. K. L.										SIGNED									
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY MM DD YY									
25. FEDERAL TAX I.D. NUMBER SSN EIN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY MM DD YY									
26. PATIENT'S ACCOUNT NO.										20. OUTSIDE LAB? \$ CHARGES									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
28. TOTAL CHARGE \$										23. PRIOR AUTHORIZATION NUMBER									
29. AMOUNT PAID \$										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
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									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # ()									
a. NPI										b. NPI									