



**HEALTH INSURANCE CLAIM FORM**

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

PICA <span style="float: right;">PICA</span>																													
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) ( ) ( )				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?    PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)																	
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						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>																	
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																													
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 ILLNESS, INJURY, or PREGNANCY (LMP) MM   DD   YY    QUAL: _____						15. OTHER DATE QUAL: _____ MM   DD   YY						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 _____						20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. RESUBMISSION CODE    ORIGINAL REF. NO.																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												23. PRIOR AUTHORIZATION NUMBER																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____    ICD Ind. _____												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/HCPCS    MODIFIER    E. DIAGNOSIS POINTER						F. \$ CHARGES    G. DAYS OR UNITS    H. EPSDT Family Plan    I. ID. QUAL.    J. RENDERING PROVIDER ID. #					
1												NPI																	
2												NPI																	
3												NPI																	
4												NPI																	
5												NPI																	
6												NPI																	
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.)  SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____						33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____																	

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION