

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <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 SEX 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)										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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Full-Time Part-Time Employed <input type="checkbox"/> Student <input type="checkbox"/> Student <input type="checkbox"/>										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 SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										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. RESERVED FOR LOCAL USE										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 _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
																				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. NPI										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
19. RESERVED FOR LOCAL USE										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 To 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. EPSTD Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																											
1																				NPI																																							
2																				NPI																																							
3																				NPI																																							
4																				NPI																																							
5																				NPI																																							
6																				NPI																																							
25. FEDERAL TAX ID 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. 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) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. b.										33. BILLING PROVIDER INFO & PH. # () a. b.																																							