



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"/>									
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"/>									
CITY										7. INSURED'S ADDRESS (No., Street)									
STATE										CITY									
ZIP CODE										STATE									
TELEPHONE (Include Area Code) () ()										ZIP CODE									
TELEPHONE (Include Area 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) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										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>									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
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.										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 _____ DATE _____										SIGNED _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____										15. OTHER DATE MM DD YY QUAL: _____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY									
17a. _____										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. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
A. _____ B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____									
E. _____ F. _____ G. _____ H. _____																			
I. _____ J. _____ K. _____ L. _____																			
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										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.)										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # ()									
a. NPI _____										b. _____									
a. NPI _____										b. _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION