

HEALTH INSURANCE CLAIM FORM

TEST VERSION – NOT FOR OFFICIAL USE

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																								
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) 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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE									
ZIP CODE					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										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. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										M <input type="checkbox"/> F <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>														
d. INSURANCE PLAN NAME OR PROGRAM NAME										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 (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										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. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____ 4. _____										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/HCPCS 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. 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. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____														

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code)										CITY STATE									
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. OTHER INSURED'S DATE OF BIRTH SEX										b. AUTO ACCIDENT? PLACE (State)									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH SEX									
a. INSURED'S DATE OF BIRTH SEX										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
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) 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										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)										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.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH #																			
SIGNED DATE a. b.										a. b.									

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CITY XXXXXXXXXXXXXXXXXXXXXXXXXXXX					STATE XXXX					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input checked="" type="checkbox"/>					CITY XXXXXXXXXXXXXXXXXXXXXXXXXXXX					STATE XXXX																																							
ZIP CODE XXXXXXXXXX					TELEPHONE (Include Area Code) (XXX) XXXXXXXXX					Employed <input checked="" type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input checked="" type="checkbox"/>					ZIP CODE XXXXXXXXXX					TELEPHONE (Include Area Code) (XXX) XXXXXXXXX																																							
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a. OTHER INSURED'S POLICY OR GROUP NUMBER XXXXXXXXXXXXXXXXXXXXXXXXXXXX										a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY XX XX XXXX M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>					SEX M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY XX XX XXXX M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>										b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO (XX)					b. EMPLOYER'S NAME OR SCHOOL NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXX					c. INSURANCE PLAN NAME OR PROGRAM NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXX																																							
c. EMPLOYER'S NAME OR SCHOOL NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXX										c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXX																																												
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1 XX XX XX XX XX XX XX XX XXXXXX XX XX XX XX XXXX XXXXXX XX XXX X NPI XXXXXXXXXXXX										2 XX XX XX XX XX XX XX XX XXXXXX XX XX XX XX XXXX XXXXXX XX XXX X NPI XXXXXXXXXXXX										3 XX XX XX XX XX XX XX XX XXXXXX XX XX XX XX XXXX XXXXXX XX XXX X NPI XXXXXXXXXXXX										4 XX XX XX XX XX XX XX XX XXXXXX XX XX XX XX XXXX XXXXXX XX XXX X NPI XXXXXXXXXXXX										5 XX XX XX XX XX XX XX XX XXXXXX XX XX XX XX XXXX XXXXXX XX XXX X NPI XXXXXXXXXXXX										6 XX XX XX XX XX XX XX XX XXXXXX XX XX XX XX XXXX XXXXXX XX XXX X NPI XXXXXXXXXXXX									
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a. XXXXXXXXXXXX										b. XXXXXXXXXXXX					a. XXXXXXXXXXXX					b. XXXXXXXXXXXX																																							

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