

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(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 MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. PATIENT STATUS Single Married Other
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) YES NO SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. AUTO ACCIDENT? YES NO 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
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 SIGNED

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? YES 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 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. #

Table with 6 rows and 10 columns for item 24. Columns include date of service, place of service, EMG, procedures, diagnosis pointer, charges, units, EPSDT, ID. qual., and rendering provider ID. #.

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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.)
32. SERVICE FACILITY LOCATION INFORMATION a. b.
33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE a. b. a. b.