



HEALTH INSURANCE CLAIM FORM

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

CARRIER

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| PICA | | | | | | | | | | PICA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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) () | | | | | 9. RESERVED FOR NUCC USE | | | | | | | | | | 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. OTHER CLAIM ID (Designated by NUCC) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. RESERVED FOR NUCC USE | | | | | | | | | | | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. RESERVED FOR NUCC USE | | | | | | | | | | | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | 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> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | 10d. CLAIM CODES (Designated by NUCC) | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | 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. | | | | | | | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | | | | | | | | | | | 17b. NPI | | | | | 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. _____ | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. _____ | | | | | B. _____ | | | | | C. _____ | | | | | D. _____ | | | | | E. _____ | | | | | F. _____ | | | | | G. _____ | | | | | H. _____ | | | | | I. _____ | | | | | J. _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. _____ | | | | | F. _____ | | | | | G. _____ | | | | | H. _____ | | | | | I. _____ | | | | | J. _____ | | | | | K. _____ | | | | | L. _____ | | | | | F. \$ CHARGES | | | | | G. DAYS OR UNITS | | | | | H. EPSTD Family Plan | | | | | I. ID. QUAL. | | | | | J. RENDERING PROVIDER ID. # | | | | | | | | | | | | | | |
| I. _____ | | | | | J. _____ | | | | | K. _____ | | | | | L. _____ | | | | | F. \$ CHARGES | | | | | G. DAYS OR UNITS | | | | | H. EPSTD Family Plan | | | | | I. ID. QUAL. | | | | | J. RENDERING PROVIDER ID. # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. EPSTD Family Plan | | | | | I. ID. QUAL. | | | | | J. RENDERING PROVIDER ID. # | | | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER | | | | | | | | | | SSN EIN | | | | | 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 | | | | | | | | | | 33. BILLING PROVIDER INFO & PH # () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED _____ | | | | | | | | | | | | | | | DATE _____ | | | | | | | | | | a. NPI | | | | | b. _____ | | | | | a. NPI | | | | | b. _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION