## HEALTH INSURANCE CLAIM FORM

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

#### PLEASE PRINT OR TYPE

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>2.</td>
<td>PATIENT’S NAME</td>
</tr>
<tr>
<td>3.</td>
<td>PATIENT’S BIRTH DATE</td>
</tr>
<tr>
<td>4.</td>
<td>INSURED’S NAME</td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT’S ADDRESS</td>
</tr>
<tr>
<td>6.</td>
<td>PATIENT RELATIONSHIP TO INSURED</td>
</tr>
<tr>
<td>7.</td>
<td>INSURED’S ADDRESS</td>
</tr>
<tr>
<td>8.</td>
<td>ZIP CODE</td>
</tr>
<tr>
<td>9.</td>
<td>OTHER INSURED’S NAME</td>
</tr>
<tr>
<td>10.</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
</tbody>
</table>

#### READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

#### SIGNED | DATE

#### 11. INSURED’S POLICY GROUP OR FICA NUMBER

#### 12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

#### 13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE, if needed to release payment of services described below.

#### 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)

#### 15. OTHER DATE

#### 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

#### 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

#### 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

#### 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

#### 20. OUTSIDE LAB?

#### 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

#### 22. REVISION CODE

#### 23. PRIOR AUTHORIZATION NUMBER

#### 24. DATE(S) OF SERVICE

#### 25. FEDERAL TAX ID NUMBER

#### 26. PATIENT’S ACCOUNT NO.

#### 27. ACCEPT ASSIGNMENT?

#### 28. TOTAL CHARGE

#### 29. AMOUNT PAID

#### 30. Routed for NUCC Use

#### 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

#### 32. SERVICE FACILITY LOCATION INFORMATION

#### 33. BILLING PROVIDER INFO & PH #

### NUCC Instruction Manual available at: www.nucc.org

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