



# HEALTH INSURANCE CLAIM FORM

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

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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    STATE		7. INSURED'S ADDRESS (No., Street)	
CITY    STATE		8. RESERVED FOR NUCC USE	
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:	
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?    PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
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. OTHER CLAIM ID (Designated by NUCC)	
		c. 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.

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, 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	
		17b. NPI _____			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. RESUBMISSION CODE    ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)		ICD Ind.		23. PRIOR AUTHORIZATION NUMBER	
A. _____ B. _____ C. _____ D. _____					
E. _____ F. _____ G. _____ H. _____					
I. _____ J. _____ K. _____ L. _____					

24. A.	DATE(S) OF SERVICE	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. #
	From MM DD YY To MM DD YY						CPT/HCPCS    MODIFIER												
1																	NPI		
2																	NPI		
3																	NPI		
4																	NPI		
5																	NPI		
6																	NPI		

25. FEDERAL TAX I.D. NUMBER    SSN EIN <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				33. BILLING PROVIDER INFO & PH # ( )			
SIGNED _____ DATE _____				a. NPI _____				a. NPI _____			