



HEALTH INSURANCE CLAIM FORM

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

PICA ☐ ☐										PICA ☐ ☐									
1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (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 SEX MM DD YY M ☐ F ☐									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐									
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:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO					a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO _____					b. OTHER CLAIM ID (Designated by NUCC) _____									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? ☐ YES ☐ NO					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ 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 QUAL _____ MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES ☐ YES ☐ NO _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										24. B. PLACE OF SERVICE EMG									
24. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS										24. D. MODIFIER									
24. E. DIAGNOSIS POINTER										24. F. \$ CHARGES									
24. G. DAYS OR UNITS										24. H. EPSDT Family Plan									
24. I. ID. QUAL										24. J. 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. 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. _____									