



# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>														
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) ( )							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. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>										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.										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. _____				
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER _____				
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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		
1											NPI			
2											NPI			
3											NPI			
4											NPI			
5											NPI			
6											NPI			
25. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/> <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		b. NPI		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION