|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Health insurance Coverage   |  |  |  |  | | --- | --- | --- | --- | | Medicare | Medicaid | Group plan | Other | |  |  |  |  | | | 2. Patient relationship to insured   |  |  |  |  | | --- | --- | --- | --- | | Self | Spouse | Child | Other | |  |  |  |  | | | | | 3. Insured’s ID Number |
| 4. Patient’s Name | | 5. Patient Birth date | | | 6. Insured’s Birth Date | |
| 7. Street Address | | 8. City | | | | 9. State |
| 10. Zip Code | | 11. Telephone | | 12. Alternate Telephone | | |
| 13. Is Patient’s Condition Related to:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | a. Employment | | b. Auto Accident | | c. Other Accident | | | Yes | No | Yes | No | Yes | No | | | | | | | |
| 14. Diagnosis or nature of illness or injury   |  |  |  |  | | --- | --- | --- | --- | | a. | b. | c. | d. | | e. | f. | g. | h. | | i. | j. | k. | l. | |  |  |  |  | | | | | | | |
| 15. Claims   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Dates of Service | | | | | | Procedure, service or supplies | | Charges | Amount Paid | |  | FROM | | | TO | | | Description | CPT/HCPCS |  |  | | a. |  |  |  |  |  |  |  |  |  |  | | b. |  |  |  |  |  |  |  |  |  |  | | c. |  |  |  |  |  |  |  |  |  |  | | d. |  |  |  |  |  |  |  |  |  |  | | e. |  |  |  |  |  |  |  |  |  |  | | f. |  |  |  |  |  |  |  |  |  |  | | g. |  |  |  |  |  |  |  |  |  |  | | | | | | | |
| 16. Total Charges | 17. Amount Paid | | 18. Amount Due | | | |