



# HEALTH INSURANCE CLAIM FORM

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

<div>PICA</div>										<div>PICA</div>																																																	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <div>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</div>										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										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										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) 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 If yes, complete items 9, 9a, and 9d.																																							
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. <div>SIGNED DATE</div>																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <div>SIGNED</div>																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE QUAL. MM DD YY										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. NPI										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										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.										F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPSDT Family Plan ID. QUAL. RENDERING PROVIDER ID. #																																																	
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER																																																											
1										NPI																																																	
2										NPI																																																	
3										NPI																																																	
4										NPI																																																	
5										NPI																																																	
6										NPI																																																	
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.										a. NPI b.																																							