HEALTH INSURANCE CLAIM FORM

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

PICA

ABC Insurance Company
567 Insurance Lane
Suite 700
Big City IL 80605

CARRIER

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X0123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe Jr, John, S	01 27 1997 M X F	Doe, John, J
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Main Street	Self Spouse Child X Other	123 Main Street
CITY: Anytown / STATE: IL	8. RESERVED FOR NUCC USE	CITY: Anytown / STATE: IL
ZIP CODE: 606101234 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 606101234 / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Mary, A	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: A1234
a. OTHER INSURED'S POLICY OR GROUP NUMBER: X9876543210	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 01 01 1958 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): Y4 112233445566
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC Insurance Company
d. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ Insurance Company	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO *If yes*, complete items 9, 9a, and 9d.

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: Signature on File DATE: 05/12/19

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: Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
05 02 2019 QUAL. 431	QUAL. 454 04 25 2019	FROM 04 25 2019 TO 05 12 2019
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. G2 Z5678901234	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
DN Jane A Smith MD	17b. NPI 9876543210	FROM 04 25 2019 TO 05 12 2019
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? X YES NO / $ CHARGES: 112500
NTEADDSurgery was unusually long due to scarring		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE: 7 / ORIGINAL REF. NO.: ABC12334567890
A. A12B34 B. C5678 C. D910 D.		23. PRIOR AUTHORIZATION NUMBER: 123456789
E. F. G. H.		
I. J. K. L.		

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														G2	Z5678901234
05	12	19	05	12	19	11	Y	99241	25	ABC	65 00	1		NPI	9876543210
2														G2	Z5678901234
05	12	19	05	12	19	11	Y	80329		ABC	40 00	1		NPI	9876543210
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd.for NUCC Use
221234567		X	12341234	X YES NO	$ 105 00	$ 22 00	

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 # (312) 5552222
Signature on File	ABC Hospital 9876 Hospital Street Anytown IL 606109876	ABC Medical Group 1234 Healthcare Street Anytown IL 606109876
SIGNED 05/12/19 DATE	a. 567891234 b. G2A1234567890	a. 9876543210 b. G2Z5678901234