STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): A123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jane Doe

3. PATIENT'S BIRTH DATE MM DD YY: 03-14-1985 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): John Doe

5. PATIENT'S ADDRESS (No., Street): 456 Elm St, Unit 5A, Springfield, IL 62703

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Springfield STATE: IL

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 62703 TELEPHONE (Include Area Code): ((555) 123-4567

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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 [X] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State): Illinois

b. EMPLOYER'S NAME OR SCHOOL NAME: XYZ Corporation

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: BlueCross BlueShield

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

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: Jane Doe 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: MM DD YY: 02-16-2025 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 02-16-2025 TO 03-10-2025

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. Emily Carter

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 02-16-2025 TO 02-20-2025

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: $400.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. M54.5 – Lower Back Pain
2. S33.5 – Sprain of Ligament of Lumbar Spine
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02-18-2025	02-18-2025	Springfield Medical Center		99213			$400.00					
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN:

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ $400.00

29. AMOUNT PAID: $ $50.00

30. BALANCE DUE: $350.00

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.)

02-22-2025

SIGNED Dr. Emily Carter DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Springfield Medical Center 789 Oak St, Springfield, IL 62702

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Springfield Medical Center 789 Oak St, Springfield, IL 62702

PIN# GRP#