



CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA										PICA			
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (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) CITY							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				
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 <input type="checkbox"/> NO <input type="checkbox"/>				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? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				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 <input type="checkbox"/> NO <input type="checkbox"/> 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.										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 _____ DATE _____										SIGNED _____			
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. 17b. 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 <input type="checkbox"/> NO <input type="checkbox"/>			
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.		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER	DIAGNOSIS POINTER	F.	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 		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		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.					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

