

PLEASE
DO NOT
STAPLE
IN THIS
AREA

HEALTH INSURANCE CLAIM FORM										PICA																			
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 11-2234-10190																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John					3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> SEX F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane																			
5. PATIENT'S ADDRESS (No., Street) 123 Any Street					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 Any Street																			
CITY Any City			STATE CA		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>					CITY Any City																			
ZIP CODE 92127			TELEPHONE (Include Area Code) (858) 555-0100		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 92127																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER G4683A																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input checked="" type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input checked="" type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>					c. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					d. INSURANCE PLAN NAME OR PROGRAM NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME Group Insur of Amer.																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
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 <u>Jdoe</u> DATE <u>01-15-2021</u>										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 <u>JaneDoe</u>																			
14. DATE OF CURRENT: MM DD YY 10 11 21					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 10 11 21					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Self					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <u>R11 . 0</u> 3. <u>R19 . 7</u> 2. <u>K59 . 00</u> 4. <u>K92 . 1</u>					23. PRIOR AUTHORIZATION NUMBER																								
24. A		B		C		D		E		F		G		H		I		J		K									
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE									
10 11 21		11				90801				170.00										1234567890									
10 11 21		11				90805				140.00										1234567890									
10 11 21		11				90812				93.00										1234567890									
25. FEDERAL TAX I.D. NUMBER 555-88-9999					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 405.00					29. AMOUNT PAID \$					30. BALANCE DUE \$				
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.) MtJackson 10/11/21 SIGNED DATE					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Mateo Jackson PhD 9876 Healthcare Ave Any Town, CA 92126					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Mateo Jackson PhD 9876 Healthcare Ave (920) 555-0101 Any Town, CA 92126 PIN# GRP#																			

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HEALTH INSURANCE CLAIM FORM

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION