



# HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX	
BECERRA, JOSE, L		05 02 1957 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
		Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE			
ZIP CODE		CITY	
TELEPHONE (Include Area Code)		STATE	
( )		( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNATURE ON FILE		a. INSURED'S DATE OF BIRTH SEX	
SIGNED DATE		MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		b. OTHER CLAIM ID (Designated by NUCC)	
MM DD YY QUAL.		c. INSURANCE PLAN NAME OR PROGRAM NAME	
15. OTHER DATE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
MM DD YY QUAL.		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17a. 17b. NPI		SIGNATURE ON FILE	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		SIGNED	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
A. H25 B. C. D. E. F. G. H. I. J. K. L.		FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
MM DD YY MM DD YY CPT/HCPCS MODIFIER		FROM MM DD YY TO MM DD YY	
25. FEDERAL TAX I.D. NUMBER SSN EIN		20. OUTSIDE LAB? \$ CHARGES	
<input type="checkbox"/> <input checked="" type="checkbox"/> 1344-5277		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
1344-5277 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		23. PRIOR AUTHORIZATION NUMBER	
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.)		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
ELADIO CHOURIO ORTIZ		16 50 1 NPI DR	
SIGNED 02 05 19 DATE		38 78 1 NPI	
32. SERVICE FACILITY LOCATION INFORMATION		30 55 1 NPI	
ALTA VISION		NPI	
a. NPI b.		NPI	
33. BILLING PROVIDER INFO & PH #		NPI	
ALTA VISION		NPI	
a. NPI b.		NPI	