

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ORTHOGROUP
PO BOX 2311
ALPHARATTA, GA 30023

PICA
(For Program in item 1)

1 MEDICARE

PICA MEDICAID

TRICARE CHAMPUS

CHAMPVA

GROUP HEALTH PLAN

FECA BLK LUNG

OTHER

1a INSURED I.D. NUMBER

(Medicare #)

(Medicaid #)

(Sponsor SSN)

(Member ID#)

(SSN or ID)

(SSN)

(ID)

2. PATIENT NAME (Last Name, First Name, Middle Initial)

3 PATIENT BIRTH DATE

SEX

4. INSURED NAME (Last Name, First Name, Middle Initial)

deepa

MM DD YY M F

10 15 1999

6 PATIENT RELATIONSHIP TO INSURED

7. INSURED ADDRESS (No., Street)

Self Spouse Child Other

8 PATIENT STATUS

CITY

State

Single Married Other

Employed Full-Time Student Part-Time Student

ZIP CODE

TELEPHONE (Include Area Code)

123456

(1234567890)

9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT CONDITION RELATED TO:

11. INSURED POLICY GROUP OR FECA NUMBER

a. OTHER INSUREDS POLICY OR GROUP NUMBER

a EMPLOYMENT ? (Current or Previous)

a INSURED DATE OF BIRTH

SEX

YES NO

b OTHER INSURED DATE OF BIRTH

SEX

b EMPLOYERS NAME OR SCHOOL

SEX

MM DD YY M F

YES NO

c EMPLOYERS NAME OR SCHOOL NAME

c OTHER ACCIDENT

c INSURANCE PLAN NAME OR PROGRAM NAME

YES NO

d. INSURANCE PLAN NAME OR PROGRAM NAME

d RESERVED FOR LOCAL USE

d IS THERE ANOTHER HEALTH BENEFIT PLAN ?

YES NO

If yes, return to & complete item 9 a-d

b INSURED OR AUTHORIZED PERSONS SIGNATURE I

authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS FIVE FIRST DATE

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

SIGNED

17a. 1 G C73647

17b. NPL 1407965015

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20 OUTSIDE LAB ?

YES NO