

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ORTHOGROUP
PO BOX 2311
ALPHARATTA, GA 30023

PICA

1 MEDICARE

MEDICAID

TRICARE
CHAMPUS

CHAMPVA

GROUP
HEALTH
PLAN

FECA BLK
LUNG

OTHER

1a INSURED I.D. NUMBER

PICA
(For Program in
item 1)

(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

Self Spouse Child Other

7. INSURED ADDRESS (No., Street)

CITY State

Chandigarh Georgia

8 PATIENT STATUS

Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT CONDITION RELATED TO:

Employed Full-Time Student Part-Time Student

11. INSURED POLICY GROUP OR FECA NUMBER

12 PATIENTS OR AUTHORIZES PERSONS 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 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

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

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20 OUTSIDE LAB ?

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3, or 4 item 24E by line)

22 MEDICAID RESUBMISSION

23 PRIOR AUTHORIZATION NUMBER

2. PATIENT ADDRESS (No., Street)

3. INSURED ADDRESS (No., Street)

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