

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 <input type="checkbox"/>	(Medicaid <input type="checkbox"/>	(Sponsor <input type="checkbox"/>	(Member <input type="checkbox"/>	(SSN or ID) <input type="checkbox"/>	(SSN) <input type="checkbox"/>	(ID) <input type="checkbox"/>

2. PATIENT NAME (Last Name, First Name, Middle Initial)	3. PATIENT BIRTH DATE	SEX	4. INSURED NAME (Last Name, First Name, Middle Initial)
deepa	.		

2. PATIENT ADDRESS (No., Street)
Chandigarh SCO no. 108-109

CITY
Chandigarh

ZIP CODE	TELEPHONE (Include Area Code)
123456	(1234567890)

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

bOTHER INSURED DATE OF BIRTH SEX

MM DD YY M ☐ F ☐

cEMPLOYERS NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

PATIENT BIRTH DATE					SEX
MM	DD	YY	M	<input type="text"/>	F <input type="text"/>
10	15	1999			

6 PATIENT RELATIONSHIP TO INSURED

Self ☐ Spouse ☐ Child ☐ Other ☐

8 PATIENT STATUS

Single ☐ Married ☐ Other ☐

Employed ☐ Full-Time ☐ Part-Time ☐

Student ☐ Student ☐

10. IS PATIENT CONDITION RELATED TO:

aEMPLOYMENT ? (Current or Previous)

bAUTO ACCIDENT

YES ☐ NO ☐

c OTHER ACCIDENT

YES ☐ NO ☐

dRESERVED FOR LOCAL USE

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

7. INSURED ADDRESS (No., Street)

CITY State

ZIP CODE	TELEPHONE (Include Area Code)
40203	()

11. INSURED POLICY GROUP
OR FECA NUMBER

aINSURED DATE OF BIRTH SEX

MM DD YY M F

bEMPLOYERS NAME OR SCHOOL . NAME

MM DD YY M ☐ F ☐

cINSURANCE PLAN NAME OR PROGRAM NAME

DIS THERE ANOTHER HEALTH BENEFIT PLAN ?
YES ☐ NO ☐ If yes, return to &
complete item 9 a-d

INSURED OR AUTHORIZED PERSONS SIGNATURE _____
 I authorize payment of medical benefits to the
 undersigned physician or supplier for services
 described below
 SIGNED _____

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM	MM		DD		YY	TO		MM		DD		YY
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<u>18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</u>							
FROM	MM		DD		YY	TO	MM DD YY
20 OUTSIDE LAB ?							\$ CHARGES

☐ YES ☐ NO

22 MEDICAID RESUBMISSION	
CODE	ORIGINAL REF NO.

23 PRIOR AUTHORIZATION NUMBER

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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

SIGNED _____ Date _____

14 DATE OF CURRENT			ILLNESS (First symptom) OR	15 IF PATIENT HAS HAD SAME OR SIMILAR		
MM	DD	YY	INJURY (Accident) OR	ILLNESS FIVE FIRST DATE		
			PREGNANCY (LMP)	MM	DD	YY

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

DR. NORMAN V LEWIS MD
19. RESERVED FOR LOCAL USE

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

1. 1718.31	3. 1726.91
2. 1718.81	4. 1338.18