

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

2. PATIENT ADDRESS (No., Street)

6 PATIENT RELATIONSHIP TO INSURED

7. INSURED ADDRESS (No., Street)

Chandigarh SCO no. 108-109

Self Spouse Child Other

CITY

STATE

8 PATIENT STATUS

CITY

State

Chandigarh

Georgia

Single Married Other

ZIP CODE

TELEPHONE (Include Area Code)

Employed Full-Time Part-Time Student Student

ZIP CODE

TELEPHONE (Include Area Code)

123456

(1234567890)

10. IS PATIENT CONDITION RELATED TO:

40203

( )

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

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

MM DD YY M F

b OTHER INSURED DATE OF BIRTH

SEX

b AUTO ACCIDENT

SEX

MM DD YY M F

YES NO

MM DD YY M F

c EMPLOYERS NAME OR SCHOOL NAME

c OTHER ACCIDENT

c INSURANCE PLAN NAME OR PROGRAM NAME

YES NO

SELF

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

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

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

SIGNED

Date

MM DD YY

MM DD YY

FROM MM DD YY TO MM DD YY

DR. NORMAN V LEWIS MD

17a. 1 G C73647

17b. NPL 1407965015

FROM MM DD YY TO MM DD YY

YES NO

CODE ORIGINAL REF NO.