

PICA ☐ ☐ ☐

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
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 type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)					
CITY				STATE		8. RESERVED FOR NUCC USE						CITY				STATE	
ZIP CODE				TELEPHONE (Include Area Code) (     )								ZIP CODE				TELEPHONE (Include Area Code) (     )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>						b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, complete items 9, 9a, and 9d.</b>					

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. 17b. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. _____						22. RESUBMISSION CODE ORIGINAL REF. NO.		
						23. PRIOR AUTHORIZATION NUMBER		

[illegible]

25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT? (for govt claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rswd. for NUCC Use			
		<input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$					
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ( )							
SIGNED				DATE				a. NPI		b.		a. NPI		b.	