

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05



<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> PICA </div> </div>																																																																																																																
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (BLK LUNG SSN) (ID)</small>						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						CITY STATE				CITY STATE																																																																																																						
ZIP CODE TELEPHONE (Include Area Code) ()						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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																						
c. EMPLOYER'S NAME OR SCHOOL NAME						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. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																						
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																																																																																																																
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)																																																																																																																
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE																																																																																																																
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)																																																																																																																
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																
23. PRIOR AUTHORIZATION NUMBER																																																																																																																
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">24. A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C. EMG</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES</th> <th>E. DIAGNOSIS</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. EPSOT Family Plan</th> <th>I. ID. QUAL</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th></th> <th>(Explain Unusual Circumstances)</th> <th>POINTER</th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> <tr> <th>MM DD YY</th> <th>MM DD YY</th> <th></th> <th></th> <th>CPT/HCPCS MODIFIER</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> </tbody> </table>														24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	From	To			(Explain Unusual Circumstances)	POINTER						MM DD YY	MM DD YY			CPT/HCPCS MODIFIER							1										NPI	2										NPI	3										NPI	4										NPI	5										NPI	6										NPI
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>																																																																																																																
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																
28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$																																																																																																																
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 # ()																																																																																																																
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