

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05



| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| PICA <input type="checkbox"/> | | | | | | | | | | PICA <input type="checkbox"/> | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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"/> | | | | | | | | | |
| 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"/> | | | | | | | | | |
| CITY STATE | | | | | | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | | | | | |
| ZIP CODE TELEPHONE (Include Area Code) () | | | | | | | | | | CITY STATE | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 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) | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | | 11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | |
| 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. | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | | | | | | |
| SIGNED DATE | | | | | | | | | | SIGNED | | | | | | | | | |
| 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 | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | | | | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES | | | | | | | | | |
| 1. _____ 3. _____ | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | | | | | | | | | |
| 2. _____ 4. _____ | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. # | | | | | | | | | | | | | | | | | | | |
| 1 | | | | | | | | | | NPI | | | | | | | | | |
| 2 | | | | | | | | | | NPI | | | | | | | | | |
| 3 | | | | | | | | | | NPI | | | | | | | | | |
| 4 | | | | | | | | | | NPI | | | | | | | | | |
| 5 | | | | | | | | | | NPI | | | | | | | | | |
| 6 | | | | | | | | | | NPI | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | 26. PATIENT'S ACCOUNT 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.) | | | | | | | | | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | 28. TOTAL CHARGE \$ | | | | | | | | | |
| a. NPI | | | | | | | | | | 29. AMOUNT PAID \$ | | | | | | | | | |
| b. NPI | | | | | | | | | | 30. BALANCE DUE \$ | | | | | | | | | |
| 33. BILLING PROVIDER INFO & PH # () | | | | | | | | | | | | | | | | | | | |
| SIGNED DATE | | | | | | | | | | a. NPI b. NPI | | | | | | | | | |