

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08-05

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1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BULK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	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)		7. INSURED'S ADDRESS (No., Street)
CITY	STATE	CITY
STATE	STATE	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()	ZIP CODE
TELEPHONE (Include Area Code) ()	8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		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. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9-c-d.
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)		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)
17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)
17b. NPI _____		19. RESERVED FOR LOCAL USE
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____)
1. _____ 3. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____
2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER _____
24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. PL/EO/OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT-HCPCS) MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT 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 () ()		26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (YES <input type="checkbox"/> NO <input type="checkbox"/>		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
SIGNED _____ DATE _____		a. _____ b. _____
		a. _____ b. _____

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION