



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA										PICA																																									
1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)		OTHER (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 F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street)																															
CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE																										
ZIP CODE					TELEPHONE (Include Area Code) ( )					9. RESERVED FOR NUCC USE										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					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					a. EMPLOYMENT? (Current or Previous) YES NO					b. AUTO ACCIDENT? PLACE (State) YES NO					c. OTHER ACCIDENT? YES NO					10d. RESERVED FOR LOCAL USE																
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.										11. INSURED'S DATE OF BIRTH MM DD YY										SEX M F		b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME									
SIGNED										DATE										SIGNED										YES NO If yes, complete items 9, 9a and 9d.																					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										15. OTHER 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. QUAL.					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 YES NO										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										A. _____ B. _____ C. _____ D. _____										E. _____ F. _____ G. _____ H. _____										I. _____ J. _____ K. _____ L. _____																					
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSTD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																															
From MM DD YY To MM DD YY																																																			
1																																																			
2																																																			
3																																																			
4																																																			
5																																																			
6																																																			
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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 # ( )																															
SIGNED										DATE										a.					b.																										

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION