



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																								
11. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.										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										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																																							
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? YES NO \$ CHARGES										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.																																							
22. RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE 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. EPSTD Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																							
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.) SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. b.										33. BILLING PROVIDER INFO & PH # () a. b.																																							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION