

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLKLUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (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)		4. INSURED'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"/>		7. INSURED'S ADDRESS (No., Street)
5. PATIENT'S ADDRESS (No., Street)		8. PATIENT STATUS
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
CITY	STATE	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
ZIP CODE	TELEPHONE (Include Area Code)	11. INSURED'S POLICY GROUP OR FECA NUMBER
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE

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.

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	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? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L. _____ 3. L. _____ 2. L. _____ 4. L. _____	23. PRIOR AUTHORIZATION NUMBER _____	

24. A. DATE(S) OF SERVICE	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. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								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		33. BILLING PROVIDER INFO & PH # ()		
SIGNED	DATE	a. NPI	b. NPI	a. NPI	b. NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER