

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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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"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						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"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																	
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"/>						7. INSURED'S ADDRESS (No., Street)																																																																																																																							
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY						STATE																																																																																																											
ZIP CODE						TELEPHONE (Include Area Code) ()						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						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						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						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						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME						PLACE (State) _____																																																																																																																	
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE																																																																																																																	
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																	
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. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																							
17b. NPI _____						19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																																																																																																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																																																																																							
1. _____												23. PRIOR AUTHORIZATION NUMBER _____																																																																																																																							
2. _____												24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE EMG												C. _____												D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/ICPCS MODIFIER												E. DIAGNOSIS PDINTER												F. \$ CHARGES												G. DAYS OR UNITS												H. EPSON 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 gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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. _____												a. _____												b. _____																																																																							

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION