

**1500**

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																
1. MEDICARE <input type="checkbox"/> (Medicare #)					MEDICAID <input type="checkbox"/> (Medicaid #)					TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)					FECA BLK LUNG <input type="checkbox"/> (SSN)					OTHER <input type="checkbox"/> (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 <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																																												
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																																												
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>																																												
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: <input type="checkbox"/> 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? <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) 1. _____ 3. _____ 2. _____ 4. _____															22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																											
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/HCP/CS 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 <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. 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.)  SIGNED _____ DATE _____															32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____															33. BILLING PROVIDER INFO & PH # ( ) a. _____ b. _____																																												

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION