

HEALTH INSURANCE CLAIM FORM

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

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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) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()															6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()																																																																																																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)															10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO										11. INSURED'S POLICY GROUP OR FECA NUMBER a. 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																																																																																																			
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 QUAL.										15. OTHER DATE MM DD YY QUAL.										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. 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										22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																			
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.															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. EPST 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										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.																																																																																																			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION