HEALTH INSURANCE CLAIM FORM

			PICA
MEDICARE MEDICAID TRICARE CHAMF (Medicare#) (Medicald#) (ID#/DcD#) (Membe	- HEALTH PLAN - BLK LUNG -	1a, INSURED'S I.D. NUMBER	(For Program in Item 1)
ATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name,	, Middle Initial)
ATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
Y STAT	Self Spouse Child Other		OTATE
T. STAT	6. RESERVED FOR NUCCUSE	OTY	STATE
CODE TELEPHONE (Include Area Code) ()		ZIP CODE TELEPHON	NE (Indude Area Code)
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA N	UMBER
THER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY	SEX E
ESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)		
ESERVED FOR NUCCUSE		C. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES NO		
SURANCE PLAN NAME OR PROGRAM NAME	10d, CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT P	LAN? ete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETI ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize th	IG & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S	S SIGNATURE I authorize
process this claim. I also request payment of government benefits eithelow,		payment of medical benefits to the undersig services described below.	gned prysidian or supplier for
IGNED	DATE	SIGNED	
M I DD I YY	OTHER DATE		
VAME OF REFERRING PROVIDER OR OTHER SOURCE	/a.	18. HOSPITALIZATION DATES RELATED TO	
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
AGNOSIS OF NATURE OF ILLNESS OF INJURY Relate A-L to se	vice line below (24E)		
		22. RESUBMISSION CODE CRIGINAL REF. NO.	
F. [G.	н.	23. PRICE AUTHORIZATION NUMBER	
	E. E. E. E. E. C. SUPPLIES E. I. I. E. I. E. I. E. I. E. I. I. E. I. I. I. AGNOSIS I. I. AGNOSIS DI AGNOSIS	F. G. H. I. DAYS ERSOT ID. SCHARGES UNITS Ran QUAL	J. RENDERING
DD YY MM DD YY SERVICE EMG OPT/HO		SCHARGES UNITS Plan QUAL	PROVIDER ID. #
		NPI	
		I NPI	
		NPI	
		NPI	
		NPI	
	ACCOUNT NO. 27 ACCEPT ASSIGNMENT? (For gover claims, see tack)	28. TOTAL CHARGE 29. AMOUNT P/	AID 80. Rsvd.for NUCC U
EDERALTAX I.D. NUMBER SSN EIN 26. PATIENT'S	(FOL GOVE CIAINS, SEE DACK)		