

HEALTH INSURANCE CLAIM FORM

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

PICA	940 Y 2040 2200 (Age 420)							PICA
I. MEDICARE MEDICAID (Medicare#) (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA GE	ROUP FECA EALTH PLAN BLK LU (ID#)	NG OTHER	1a. INSURED'S I.D. NU	JMBER	(F	For Program in Item 1)
2. PATIENT'S NAME (Last Name,			NT'S BIRTH DATE	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street)			NT RELATIONSHIP TO IN Spouse Child	7. INSURED'S ADDRESS (No., Street)				
CITY STATE			RVED FOR NUCC USE		CITY			STATE
TELEPHONE (Include Area Code)					ZIP CODE	TE	LEPHONE (In	dude Area Code)
OTHER INSURED'S NAME (La:	st Name, First Name, Middle Ir	nitial) 10. IS PAT	TIENT'S CONDITION REL	ATED TO:	11. INSURED'S POLIC	Y GROUP OR	FECA NUMB	ER
a, OTHER INSURED'S POLICY OR GROUP NUMBER			DYMENT? (Current or Pres	a. INSURED'S DATE OF BIRTH MM DD YY M F				
b. RESERVED FOR NUCC USE			ACCIDENT?	PLACE (State)				
RESERVED FOR NUCCUSE		c. OTHER	R ACCIDENT?	0	c. INSURANCE PLAN I	NAME OR PRO	OGRAM NAM	E
d, INSURANCE PLAN NAME OR PROGRAM NAME			M CODES (Designated by	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? VES NO If yes, complete items 9, 9a, and 9d.				
READ B PATIENT'S OR AUTHORIZED to process this claim. I also requiselow.		ithorize the release of a	ny medical or other informa		13. INSURED'S OR AU	THORIZED PE	RSON'S SIG	
SIGNED			DATE		SIGNED_			
DATE OF CURRENT ILLNESS MM DD YY QU	S, INJURY, OF PREGNANCY (L IAL.	MP) 15. OTHER DA	TE MM DD	Ϋ́Υ	16. DATES PATIENT U MM DD FROM	INABLE TO W	ORK IN CURE M TO	RENT OCCUPATION M DD YY
NAME OF REFERRING PROV	IDER OR OTHER SOURCE	17a. 17b. NPI			18. HOSPITALIZATION MM DD FROM	DATES RELA	TED TO CUF M TO	RENT SERVICES M DD YY
, ADDITIONAL CLAIM INFORM	ATION (Designated by NUCC)				20. OUTSIDE LAB?	NO	\$ CHAF	RGES
, DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY Relate		(CD Ind.		22. RESUBMISSION CODE	ORI	GINAL REF.	NO.
	G.L	— в <u>—</u> н <u>—</u>	23. PRIOR AUTHORIZATION NUMBER					
A. DATE(S) OF SERVICE From To M DD YY MM DI	o PLACE OF	D. PROCEDURES, SE (Explain Unusual CPT/HCPCS	ERVICES, OR SUPPLIES Circumstances) MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. H. DAYS EPSD OR Famil UNITS Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
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5. FEDERALTAX I.D. NUMBER	SSN EIN 26. P	ATIENT'S ACCOUNT I	NO. 27. ACCEPT A Forgovit clai	SSIGNMENT? ns, see back) NO	28. TOTAL CHARGE \$	29. AM	OUNT PAID	80. Rsvd for NUCC L
I. SIGNATURE OF PHYSICIAN (INCLUDING DEGREES OR O (I certify that the statements on apply to this bill and are made	REDENTIALS the reverse	ERVICE PACILITÝ LO	CATION INFORMATION		33. BILLING PROVIDE	R INFO & PH #	* ()
IGNED	DATE a.	HUT	b.		a.	ь.		
0011					ACTORIS	NOTE IN A STATE OF		