



HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane					3. PATIENT'S BIRTH DATE SEX 02 02 1970 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) 341 Tosca Way					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 Houston			STATE TX		8. RESERVED FOR NUCC USE					CITY			STATE						
ZIP CODE 77485		TELEPHONE (Include Area Code) (123) 555-1234			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 checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. OTHER CLAIM ID (Designated by NUCC)						
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>						
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					d. INSURANCE PLAN NAME OR PROGRAM NAME			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					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 _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. S31112A B. T790XXA C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			22. 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/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
01 01 2016 01 01 2016		3	9	A0429 ET SH				A,B	40.00	1	NPI								
01 01 2016 01 01 2016		3	9	A0422 ET SH				C,D	20.00	1	NPI								
01 01 2016 01 01 2016		3	9	A0382 ET SH				A,B	2.00	2	NPI								
01 01 2016 01 01 2016		3	9	A0382 ET SH				A	15.00	5	NPI								
01 01 2016 01 01 2016		3	9	A0425 ET SH				B	48.00	8	NPI								
01 01 2016 01 01 2016		3	9	A0429 ET SH				A,B	40.00	1	NPI								
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. 12345					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 123.00		29. AMOUNT PAID \$ _____		30. Rsvd for NUCC Use		
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.) Signature on File 01012016 SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION Junction Hospital 332 Junction Street Houston, TX 77883					33. BILLING PROVIDER INFO & PH # () Spindle Ambulance 4000 Main Street Houston, TX 77883			a. 4302198765 b. 9876543021		a. 9876543021 b. 1234567-01				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION