



# 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) <b>123456789</b>																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>															3. PATIENT'S BIRTH DATE MM DD YY <b>12 20 1993</b>										SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																													
5. PATIENT'S ADDRESS (No., Street) <b>2242 Spencer</b>															6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>															7. INSURED'S ADDRESS (No., Street)																													
CITY <b>Pharr</b>										STATE <b>TX</b>					8. RESERVED FOR NUCC USE										CITY					STATE																													
ZIP CODE <b>78535</b>					TELEPHONE (Include Area Code) ( )										9. RESERVED FOR NUCC USE										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 checked="" type="checkbox"/> NO															a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE															b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)															b. OTHER CLAIM ID (Designated by NUCC)																													
c. RESERVED FOR NUCC USE															c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															c. INSURANCE PLAN NAME OR PROGRAM NAME																													
d. INSURANCE PLAN NAME OR PROGRAM NAME															10d. CLAIM CODES (Designated by NUCC)															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>																													
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. <b>Signature on File</b> 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. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
17b. NPI _____															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															22. RESUBMISSION CODE ORIGINAL REF. NO.																																												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b> A. <b>H540</b> 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. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
<b>01 01 2016 01 01 2016</b>										<b>2</b>					<b>G9012</b>										<b>A</b>					<b>100.00</b>					<b>1</b>					<b>NPI</b>																			
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25. FEDERAL TAX I.D. NUMBER										SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>123456</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>100.00</b>					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.) <b>Richard Glass</b> 01 10 2016 SIGNED _____ DATE _____															32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b. _____															33. BILLING PROVIDER INFO & PH # ( ) <b>DARS Division for Blind Services</b> <b>1200 Front St.</b> <b>Pharr, TX 78201</b> a. <b>9876543021</b> b. <b>1234567-01</b>																													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION