



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) M123456789			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane						3. PATIENT'S BIRTH DATE MM DD YY 08 03 1981				SEX 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) 1523 Robinson Street						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 Laredo				STATE TX		8. RESERVED FOR NUCC USE						CITY				STATE					
ZIP CODE 79701				TELEPHONE (Include Area Code) (209) 555-1234								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) <input type="checkbox"/>						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. Signed <u>Signature on File</u> 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 _____						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. D259 B. N923 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
23. PRIOR AUTHORIZATION NUMBER 123456789																					
24. A. DATE(S) OF SERVICE		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. #	
MM DD YY		MM DD YY																			
01 07 2016		01 07 2016		03		58260				A		970.00								5432109876	
1																				1234567-89	
2																				NPI	
3																				NPI	
4																				NPI	
5																				NPI	
6																				NPI	
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO. 12345				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 970.00		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.) Jane Smith, MD SIGNED						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____						33. BILLING PROVIDER INFO & PH # () Women's Health Center 921 Raitte Place Goliad, TX 77963 a. 9876543021 b. 1234567-01									
DATE 01/10/2016																					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION