



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 M.					3. PATIENT'S BIRTH DATE MM DD YY 10 15 2001 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) 300 Atlantic Ave.					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 Paris			STATE TX		8. RESERVED FOR NUCC USE					CITY			STATE																
ZIP CODE 75460			TELEPHONE (Include Area Code) (903) 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) _____					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 _____ 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 type="checkbox"/> NO \$ CHARGES _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																			
A. G803 B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER 9892126567																			
E. _____ F. _____ G. _____ H. _____																													
I. _____ J. _____ K. _____ L. _____																													
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				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		CPT/HCPCS	MODIFIER																					
01	01	2016	01	01	2016	1	G9012	U2	U5	A		60.00	1			NPI		1234567-89		9087654321									
01	01	2016	01	01	2016	1	G9012	TS	U5	A		60.00	1			NPI		1234567-89		9087654321									
01	01	2016	01	01	2016	1	G9012	TS		A		20.00	1			NPI		1234567-89		9087654321									
																NPI													
																NPI													
																NPI													
25. FEDERAL TAX I.D. NUMBER					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back)					28. TOTAL CHARGE					29. AMOUNT PAID					30. Rsvd for NUCC Use				
					12345					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					\$ 140.00					\$ _____									
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.) Robert Jackson 01 10 2016 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # () 123 Case Management Inc. 1200 Medical Circle Paris, TX 75460 a. 9876543021 b. 1234567-01									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION