



HEALTH INSURANCE CLAIM FORM

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

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					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? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										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.					17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. Z331 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER 9892126567														
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. EPSTD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #									
1 01 01 2025		01 01 2025		1		G9012 U2 U5				A		146.16		1		NPI		123X00000X		9087654321									
2 01 05 2025		01 05 2025		1		G9012 TS U5				A		122.31		1		NPI		123X00000X		9087654321									
3 01 12 2025		01 12 2025		1		G9012 TS 93				A		29.36		1		NPI		123X00000X		9087654321									
4																NPI													
5																NPI													
6																NPI													
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					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 \$ 140.00					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.) Robert Jackson 01 15 2025 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # () 123 Case Management Inc. 1200 Medical Circle Paris, TX 75460-1234 a. 9876543021 b. 123X00000X									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION