



# 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, Jane M.</b>					3. PATIENT'S BIRTH DATE    SEX MM DD YY    M <input type="checkbox"/> F <input checked="" type="checkbox"/> <b>09 14 1998</b>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) <b>1201 Carning Place</b>					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 <b>Plano</b>			STATE <b>TX</b>		8. RESERVED FOR NUCC USE					CITY			STATE																
ZIP CODE <b>75432</b>			TELEPHONE (Include Area Code) (    )							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    SEX MM DD YY    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?    PLACE (State) <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 <b>Signature on File</b> 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 <b>Paul Burnes MD</b>										17a.					17b. NPI <b>1234567089</b>					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 checked="" type="checkbox"/> NO										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>S06890D</b> B.    C.    D.    E.    F.    G.    H.    I.    J.    K.    L.										23. PRIOR AUTHORIZATION NUMBER <b>999266123</b>																			
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>B9998</b>				<b>A</b>		<b>120.00</b>		<b>1</b>		<b>NPI</b>															
<b>01 01 2016 01 01 2016</b>		<b>2</b>		<b>T4529</b>				<b>A</b>		<b>15.00</b>		<b>50</b>		<b>NPI</b>															
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25. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>1234567</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>135.00</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>David Patton</b> 01 10 2016 SIGNED    DATE										32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b.										33. BILLING PROVIDER INFO & PH # (    ) <b>General Supply Company</b> <b>1902 Bunker Hill</b> <b>Hillsboro, TX 74932</b> a. <b>9876543021</b> b. <b>1234567-01</b>									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION