



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 J.										3. PATIENT'S BIRTH DATE MM DD YY 08 03 1953 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) 942 Hartford Drive										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 Comfort					STATE TX					8. RESERVED FOR NUCC USE									
ZIP CODE 78013					TELEPHONE (Include Area Code) (512) 555-1234					CITY									
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 <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 Stan Levelson MD										17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
17b. NPI 1234567089										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					23. PRIOR AUTHORIZATION NUMBER _____				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. Z0000 B. N058 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										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. #									
1 01 01 2016 01 01 2016 6 80053 A 18.17										2 01 01 2016 01 01 2016 6 88305 A 45.42									
3 01 01 2016 01 01 2016 6 88346 A 18.27										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 \$ 81.86				
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.) Signature on File 01 09 2016 SIGNED DATE									
32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # () ABC Laboratory Services 1242 Medical Place Comfort, TX 78013 a. 9876543021 b. 1234567-01									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION