HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F / 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other / 7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8.RESERVED FOR NUCC USE / CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10.IS PATIENT CONDITION RELATIED TO: / 11. INSURED'S POLICY GROUP OR FECA NUMBER 1548
a. OTHER INSURED'S POLICY NUMBER OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO / a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b.IRESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State) / b.OTHER CLAIM ID (Designated by NUCC)
c.RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES 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? Yes No If yes, complete items 9, 9a and 9d

READ BACK OF FORM BEFORE COMPLETEING & SIGNING THIS FORM

12 PATIENT'S OR AUTHORIZIED 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 QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21.DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. MEDICAID RESUBMISSION CODE / ORIGNAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENTS ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For Govt. Claims, see back) YES NO	28. TOTAL CHARGE $	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 part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # a. b.		