## **HEALTH INSURANCE CLAIM FORM**

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HEALTH INSURANCE CLA	AIM FORM						
APPROVED BY NATIONAL UNIFORM CLAIM CO							
PICA						PICA	
. MEDICARE MEDICAID TRICAR	RE CHAMPV	'A GROUP	FECA OTHER BLK LUNG	1a. INSURED'S I.D. NUMBE	R	(For Program in Item 1	1)
(Medicare #) (Medicaid #) (Sponso	or's SSN) (Member II	D#) (SSN or ID)	SSN) (ID)				
:. PATIENT'S NAME (Last Name, First Name, Mid	ddle Initial)	3. PATIENT'S BIRTH DATE	SEX M F	4. INSURED'S NAME (Last f	Name, First Name,	, Middle Initial)	
. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP	TO INSURED	7. INSURED'S ADDRESS (N	lo., Street)		
		Self Spouse Ch	ild Other				
HTY	STATE			CITY		STATE	
IP CODE TELEPHONE (	(Include Area Code)	Single Married	Other	ZIP CODE	TELEBUON	JE (Include Area Code)	
( )	(molade Area Oode)	Employed Full-Time	Part-Time	Zii OOBE	1	)	
OTHER INSURED'S NAME (Last Name, First N	Vame Middle Initial)	Employed Student  10. IS PATIENT'S CONDITIO	Student Studen	11. INSURED'S POLICY GR	OUP OR FECA N		
	Tamo, masio malay						
OTHER INSURED'S POLICY OR GROUP NUM	ИВЕR	a. EMPLOYMENT? (Current	or Previous)	a. INSURED'S DATE OF BIF	RTH VY	SEX	
		YES	NO	MM DD '	r Y N	f F	
OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME OR	SCHOOL NAME		
M	F	YES	NO				
EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME	OR PROGRAM I	VAME	
INICHIOANICE OF AN NAME OF SOCOOD CO.	5.4 <i>C</i>	YES YES	NO	d to Tuene Anothen us	ALTH DENICET O	I AN2	
INSURANCE PLAN NAME OR PROGRAM NAI	10d. RESERVED FOR LOCA	L USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO If yes, return to and complete item 9 a-d.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize				
READ BACK OF FOR	G & SIGNING THIS FORM.						
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGN to process this claim. I also request payment of below.</li> </ol>	GNATURE I authorize the	release of any medical or other i			fits to the undersig	gned physician or supplier	
SIGNED		DATE		SIGNED			
4. DATE OF CURRENT:   ILLNESS (First s	symptom) OR 15.	IF PATIENT HAS HAD SAME GIVE FIRST DATE MM	OR SIMILAR ILLNESS.	16. DATES PATIENT UNAB	E TO WORK IN (	OURRENT OCCUPATION	, ,
MM DD YY INJURY (Accider PREGNANCY(LI	GIVE FIRST DATE MM	אין טכ	I FROM TO				
7. NAME OF REFERRING PROVIDER OR OTH	IER SOURCE 17a	а.		18. HOSPITALIZATION DAT	ES RELATED TO	CURRENT SERVICES MM . DD . YY	,
	b. NPI		FROM TO				
9. RESERVED FOR LOCAL USE				20. OUTSIDE LAB?	\$ (	CHARGES	
1. DIAGNOSIS OR NATURE OF ILLNESS OR II	N.II.IBV (Polate Home 1 2	3 or 4 to Item 245 by Lino\		YES NO 22. MEDICAID RESUBMISS	ION		
	,		+	CODE	ORIGINAL F	REF. NO.	
1,	3.		e e	23. PRIOR AUTHORIZATIO	N NUMBER		
2.	4.	1					
24. A. DATE(S) OF SERVICE	B. C. D. PROCE	EDURES, SERVICES, OR SUP		F. OA	i. H. I.	J.	
	ACE OF (Expla PRVICE EMG CPT/HCP	ain Unusual Circumstances) PCS   MODIFIER	DIAGNOSIS POINTER	S CHARGES UN	i. H. I. YS EPSDT ID. Family ID. ITS Plan QUAL.	RENDERING PROVIDER ID.	
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25. FEDERAL TAX I.D. NUMBER SSN E	EIN 26. PATIENT'S	ACCOUNT NO 27 ACC	EPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT P	AID 30. BALANCE E	DUF
10. FEDERAL TAX I.U. NUMBER SSN E	Zo, PAHENTS	ACCOUNT NO. 27. ACC	EPT ASSIGNMENT? lovt. claims, see back)	\$	S S	S SALANCE L	ا
	32. SERVICE F/	ACILITY LOCATION INFORMA	<u>L</u>	33. BILLING PROVIDER INF	1	1,0	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	52. SERVICE 17	The state of the s			(	,	
apply to this bill and are made a part thereof.)							
SIGNED DATE	a.	b.		a.	þ.		
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## **HEALTH INSURANCE CLAIM FORM**

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	FORM CLAIM COMMITTEE 08/0									
PICA	51 527 53									PICA [
MEDICARE MEDICA	D TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PI	E	ECA OTHER	1a. INSURED'S I.D. I	NUMBER		(	For Program in Item 1)
(Medicare #) (Medicaio	#) CHAMPUS (Sponsor's SSN)	(Member ID#)	HEALTH PI (SSN or ID)	LAN M	EK LUNG SSN) (ID)					
PATIENT'S NAME (Last Nam	e, First Name, Middle Initial)	3. P	ATIENT'S BIR'	TH DATE	SEX	4. INSURED'S NAME	(Last N	ame, First	Name, Mic	ddle Initial)
					И <u></u>					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)				
DITY STATE			Self Spouse Child Other  8. PATIENT STATUS			CITY				STATE
11		STATE O. P	Single Single	Married	Other	CIT				JOINIL
P CODE	TELEPHONE (Include Area (	Code)	Girigio	L		ZIP CODE		TELE	PHONE (I	nclude Area Code)
	( )	Er		Full-Time   Student	Part-Time Student			(	( )	
OTHER INSURED'S NAME (	ast Name, First Name, Middle I	nitial) 10. I	- Immorant	in the same of the	N RELATED TO:	11. INSURED'S POL	ICY GRO	DUP OR FI	ECA NUME	BER
OTHER INSURED'S POLICY	OR GROUP NUMBER	a. E	a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH SEX				
OTHER MOURERY SATES	F DIDTH		اــــــا	YES [	NO	1	i		м 📗	J FLJ
OTHER INSURED'S DATE C	327	7 b. A	UTO ACCIDEN.	_	PLACE (State)	b. EMPLOYER'S NA	ME OR S	SCHOOL N	IAME	
EMPLOYER'S NAME OR SC	M F		THER ACCIDE	YES [	NO L	C INSTRANCE DI AT	U NIARAC	OB BBOO	BAMMAN	ME
E EOTERO NAME UN SU	TOOL INCHINE	, c. O	[]	res [	No	c. INSURANCE PLAN NAME OR PROGRAM NAME			1 lus	
INSURANCE PLAN NAME O	R PROGRAM NAME	10d.	10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO If yes, return to and complete item 9 a-d.				
S. MOST MAYE : EMA PANYE OTT HOGHANY HANYE										
	BACK OF FORM BEFORE CO				formation near			IZED PER	SON'S SIG	GNATURE I authorize
to process this claim. I also re	D PERSON'S SIGNATURE I as quest payment of government be					payment of medic services describe		ts to the u	ndersigned	I physician or supplier fo
below.										
SIGNED			DATE			SIGNED				
I. DATE OF CURRENT:	ILLNESS (First symptom) OR INJURY (Accident) OR	15. IF PA GIVE	TIENT HAS HA FIRST DATE	AD SAME O MM   D	R SIMILAR ILLNESS D YY		UNABLI	E TO WOF	Λ.	RENT OCCUPATION
	PREGNANCY(LMP)  OVIDER OR OTHER SOURCE	170		<u> </u>		FROM 18 HOSPITALIZATIO	N DATE	S BEL ATI	TO FD TO CU	BRENT SERVICES
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.			a.   D. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO				
			`1			20. OUTSIDE LAB? S CHARGES				
						YES	NO			
1. DIAGNOSIS OR NATURE C	F ILLNESS OR INJURY (Relate	Items 1, 2, 3 or 4	to Item 24E by	y Line)		22. MEDICAID RESU	BMISSI	ODIC NC	INAL REF.	NO
1		3			*			Jane	n vone i Hef.	
						23. PRIOR AUTHOR	IZATION	NUMBER	}	
2. L		4								
4. A. DATE(S) OF SERVI From	To PLACE OF		usual Circumst	ances)	DIAGNOSIS		G. DAY OR UNIT	H. S EPSDT Family S Plan	I. ID.	J. RENDERING
MM DD YY MM	DD YY SERVICE EMG	CPT/HCPCS	<u>  M</u>	IODIFIER	POINTER	\$ CHARGES	UNIT	S Plan	QUAL.	PROVIDER ID. #
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Mark Mark Mark Mark Mark Mark Mark Mark						1			NIDI	202 203 207 208 108 27 34 34 108 24 201 2
5. FEDERAL TAX I.D. NUMBE	R SSN EIN 26. P	'ATIENT'S ACCO	UNT NO.	27. ACCF	EPT ASSIGNMENT?	28. TOTAL CHARGE	: 1	29. AMOL	JNT PAID	30. BALANCE DU
				YES		s		\$		S
1. SIGNATURE OF PHYSICIA		ERVICE FACILIT	Y LOCATION			33. BILLING PROVID	ER INFO		7	7
INCLUDING DEGREES OR (I certify that the statements	CREDENTIALS								ì	,
apply to this bill and are made										
SIGNED	DATE a.		b.			a.		b.		