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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Form fields including: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER, 2. PATIENT'S NAME, 3. PATIENT'S BIRTH DATE, 4. INSURED'S NAME, 5. PATIENT'S ADDRESS, 6. PATIENT RELATIONSHIP TO INSURED, 7. INSURED'S ADDRESS, 8. PATIENT STATUS, 9. OTHER INSURED'S NAME, 10. IS PATIENT'S CONDITION RELATED TO?, 11. INSURED'S POLICY GROUP OR FECA NUMBER, 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE, 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE, 14. DATE OF CURRENT ILLNESS, 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, 16. DATES PATIENT UNABLE TO WORK, 17. NAME OF REFERRING PROVIDER, 18. HOSPITALIZATION DATES, 19. RESERVED FOR LOCAL USE, 20. OUTSIDE LAB?, 21. DIAGNOSIS OR NATURE OF ILLNESS, 22. MEDICAID RESUBMISSION CODE, 23. PRIOR AUTHORIZATION NUMBER, 24. A-E. DATE(S) OF SERVICE, 25. FEDERAL TAX I.D. NUMBER, 26. PATIENT'S ACCOUNT NO., 27. ACCEPT ASSIGNMENT?, 28. TOTAL CHARGE, 29. AMOUNT PAID, 30. BALANCE DUE, 31. SIGNATURE OF PHYSICIAN OR SUPPLIER, 32. SERVICE FACILITY LOCATION INFORMATION, 33. BILLING PROVIDER INFO & PH #.