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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE <input type="checkbox"/> (Medicare #) X MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Programs in Item 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A.	3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST	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 ANYTOWN	STATE WI	CITY
ZIP CODE 55555	TELEPHONE (Include Area Code) XXX XXX-XXXX	ZIP CODE
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER M-7 a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.
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 _____ 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: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	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 I.M. REFERRING PROVIDER	17a. _____ 17b. NPI 0123456780	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V72.5 2. _____ 3. _____ 4. _____	23. PRIOR AUTHORIZATION NUMBER	25. FEDERAL TAX I.D. NUMBER SSN EIN 1234JED
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	26. PATIENT'S ACCOUNT NO. 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO
28. TOTAL CHARGE \$ XXX XX	29. AMOUNT PAID \$ XXXX	30. BALANCE DUE \$ XX XX
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.) I.M. Provider MM/DD/YY	32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____	33. BILLING PROVIDER INFO & PH # I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION