

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) XXXXXXXXXX
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JANE L	3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JANE L
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5. PATIENT'S ADDRESS (No., Street) 789 ANY ST	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) 789 ANY ST
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CITY ALASKATOWN STATE AK	8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	CITY ALAKSATOWN STATE AK
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ZIP CODE 99123 TELEPHONE (Include Area Code) (907) 555-5555	ZIP CODE 99123 TELEPHONE (Include Area Code) (907) 555-5555
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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 (XXXXXXXXXX) TPL POLICY #
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a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) (YES <input type="checkbox"/> NO <input type="checkbox"/>	a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/> 01 10 1950
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b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? (YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____)	b. EMPLOYER'S NAME OR SCHOOL NAME (EMPLOYMENT COMPANY) NAME OF TPL
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c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? (YES <input type="checkbox"/> NO <input type="checkbox"/>	c. INSURANCE PLAN NAME OR PROGRAM NAME (PRIVATE INSURANCE COMPANY)
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d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.
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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 SIGNATURE ON FILE 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 SIGNATURE ON FILE
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14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	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)
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (LASTNAME, FIRSTNAME)	17a. ZZ 321000000X 17b. NPI 3214567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)
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19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____)
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. XXX XX 2. XXX XX 3. _____ 4. _____	22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	23. PRIOR AUTHORIZATION NUMBER _____
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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. #
08 05 10 08 05 10	X		XXXXXX	XX	200 00	1		ZZ NPI	456000000X 0987654321
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

BALANCE MINUS TPL PAID AMOUNT

AMOUNT PAID BY TPL

25. FEDERAL TAX I.D. NUMBER (123456789) SSN EIN () (X)	26. PATIENT'S ACCOUNT NO. (1432567890X)	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES () NO	28. TOTAL CHARGE \$ (200 00)	29. AMOUNT PAID \$ (50 00)	30. BALANCE DUE \$ (150 00)
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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.)	32. SERVICE FACILITY LOCATION INFORMATION (ALASKA MEDICAL OFFICE 555 FAKE ST ANYTOWN AK 99555-5555)	33. BILLING PROVIDER INFO & PH # (907) 555-1234 (ALASKA MEDICAL OFFICE P O BOX 555 ANYTOWN AK 99555-5555)
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SIGNED _____ DATE _____	a. NPI _____ b. _____	a. 5555555555 b. ZZD98700000D
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CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN SUPPLIER INFORMATION

1 HOSPITAL PATIENT ACCOUNTS PO BOX 123 ALASKATOWN AK 12345 907555555		2 HOSPITAL PATIENT ACCOUNTS PO BOX 123 ALASKATOWN AK 12345 907555555		3a PAT. CNTL # 1122334455 b. MED. REC. # 109876		4 TYPE OF BILL XXXX	
5 FED. TAX NO 0X0X				6 STATEMENT COVERS PERIOD FROM 062510 THROUGH 062510		7	

8 PATIENT NAME a DOE JOHN P		9 PATIENT ADDRESS a ALASKATOWN c AK d 99123 e																			
10 BIRTHDATE 04062000		11 SEX F		12 DATE 062510		ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 10 X X X X		17 STAT X		CONDITION CODES 22 23 24 25 26 27 28										29 ACCT STATE 30	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37									

38 DOE JANE M PO BOX 321 ALASKATOWN AK 99123										39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT	
a										b		c		d	

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
XXX	PHARMACY		062510	X	10 00		
XXX	LABORATORY	XXXXX	062510	X	5000		
XXX	PRO FEE		062510	X	10000		
XXX	INX12345XX	JXXXX	062510	X	5 00		

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CREATION DATE 080110

TOTALS 16500

50 PAYER NAME PRIVATE INSURANCE COMPANY Name of primary TPL		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN. X		54 PRIOR PAYMENTS 3000 Amount paid by TPL		55 EST. AMOUNT DUE		56 NPI 1234567890		57 OTHER ZZ123D00000X PRV ID	
58 INSURED'S NAME DOE JANE M Name of insured		59 P. REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXX Insured's ID number		61 GROUP NAME PRIVATE INSURANCE COMPANY		62 INSURANCE GROUP NO. XXXX Insurance group number		63 TREATMENT AUTHORIZATION CODES		64 CONTROL NUMBER		65 EMPLOYER NAME EMPLOYMENT COMPANY Name of employer	

66 DX XXXX		67		68					
69 ADMIT DX XXXX		70 PATIENT REASON DX XXXX		71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE DATE		a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75		76 ATTENDING NPI 0987654321 QUAL ZZ 321D00000X LAST ANYNAME FIRST JOE	
c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL LAST FIRST		78 OTHER NPI QUAL LAST FIRST	
80 REMARKS		81CC a		b		c		d	