



HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) (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 SEX MM DD YY M F									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code)										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO 10d. CLAIM CODES (Designated by NUCC)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME									
b. RESERVED FOR NUCC USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.									
c. RESERVED FOR NUCC USE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
d. INSURANCE PLAN NAME OR PROGRAM NAME										SIGNED									
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									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? \$ CHARGES YES NO 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. B. C. D. E. F. G. H. I. J. K. L.										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER MM DD YY MM DD YY SERVICE CPT/HCPCS MODIFIER									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
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									
SIGNED										DATE									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO										28. TOTAL CHARGE \$									
29. AMOUNT PAID \$										30. Rsvd for NUCC use									
33. BILLING PROVIDER INFO & PH. #										33. BILLING PROVIDER INFO & PH. #									