

## **HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICARE MEDICAID TRICARE CHAMPUS CHAMPUS	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER	PICA [
(Medicare #)   (Medicaid #)   (Sponsor's SSN)   (Member III)   PATIENT'S NAME (Last Name, First Name, Middle Initial)	D#) (SSN or ID) (SSN) (ID)  3. PATIENT'S BIRTH DATE SEX MM   DD   YY	4. INSURED'S NAME (Last Name, F	First Name, Middle Initial)
	MM   DD   YY   M   F		
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Stre	eet)
TV.	Self Spouse Child Other	OUTV	OTATE
TY STATE	8. PATIENT STATUS Single Married Other	CITY	STATE
P CODE TELEPHONE (Include Area Code)	Single Warned Onler	ZIP CODE T	ELEPHONE (Include Area Code)
( )	Employed Full-Time Part-Time Student Student		( )
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OF	R FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX M F F
OTHER INSURED'S DATE OF BIRTH SEX	h AUTO ACCIDENT?	b. EMPLOYER'S NAME OR SCHOO	
MM DD YY SEX	PLACE (State)		
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PE	ROGRAM NAME
	YES NO		
NSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH B	
READ BACK OF FORM BEFORE COMPLETING	S & SIGNING THIS FORM	YES NO If y  13. INSURED'S OR AUTHORIZED F	res, return to and complete item 9 a-d. PERSON'S SIGNATURE I authorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either below.	release of any medical or other information necessary		ne undersigned physician or supplier fo
SIGNED	DATE	SIGNED	
DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY	16. DATES PATIENT UNABLE TO V	WORK IN CURRENT OCCUPATION MM   DD   YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE 178		FROM	ATED TO CURRENT SERVICES
	 NPI	18. HOSPITALIZATION DATES REL MM   DD   YY FROM	MM DD YY
RESERVED FOR LOCAL USE	.,,,	20. OUTSIDE LAB?	\$ CHARGES
		YES NO	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2,	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE O	RIGINAL REF. NO.
3.	· · · · · · · · · · · · · · · · · · ·	23. PRIOR AUTHORIZATION NUMB	RER
4.	1	20.1 THOM THOMES AND THOMES	
A. DATE(S) OF SERVICE B. C. D. PROCE	DURES, SERVICES, OR SUPPLIES E.	F. G. I	H. I. J.
From	ain Unusual Circumstances) DIAGNOSIS CS   MODIFIER POINTER	I OR IFa	rmily ID. RENDERING PROVIDER ID. #
		1 1 1	
			NPI
			NPI
			NPI
!!!!!!!		. ! ! .	
			NPI
			NPI
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AN	NPI 30. BALANCE DU
SON EIN 20. FATIENTS A	YES NO	\$   \$	SO. BALANCE DO
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.)	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH	
a. N	b.	a. b.	