

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (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 MM   DD   YY M F			SEX M F			4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other						7. INSURED'S ADDRESS (No., Street)									
CITY				STATE		8. PATIENT STATUS Single Married Other						CITY				STATE					
ZIP CODE				TELEPHONE (Include Area Code) ( )								ZIP CODE				TELEPHONE (Include Area Code) ( )					
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? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME									
a. OTHER INSURED'S POLICY OR GROUP NUMBER						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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: 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									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY						17b. NPI							
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES YES NO				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. _____ 3. _____ 2. _____ 4. _____												23. PRIOR AUTHORIZATION NUMBER									
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. #	
1																				NPI	
2																				NPI	
3																				NPI	
4																				NPI	
5																				NPI	
6																				NPI	
25. FEDERAL TAX I.D. NUMBER				SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
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.) SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____						33. BILLING PROVIDER INFO & PH # ( ) a. _____ b. _____									