



HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) 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 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										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? ☐ YES ☐ NO c. OTHER ACCIDENT? ☐ YES ☐ NO 10d. CLAIM (Designated by)										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐										b. OTHER CLAIM ID (Designated by NUCC)																																																	
b. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? ☐ YES ☐ NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																	
c. RESERVED FOR NUCC USE										10d. CLAIM (Designated by)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.																																																	
d. INSURANCE PLAN NAME OR PROGRAM NAME										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information needed to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.										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 _____ DATE _____										SIGNED _____ DATE _____										SIGNED _____ DATE _____																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										15. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 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 SOURCE										17a. NAME OF REFERRING PROVIDER OR SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																	
17b. NAME OF REFERRING PROVIDER OR SOURCE										17c. NAME OF REFERRING PROVIDER OR SOURCE										19. ADDITIONAL CLAIM INFORMATION (Designated by)																																																	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										21. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										22. PRIOR AUTHORIZATION NUMBER _____																																																	
A. _____ B. _____ C. _____ D. _____										E. _____ F. _____ G. _____ H. _____										I. _____ J. _____																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To 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. #										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. Rsvd for NUCC Use									
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										33. BILLING PROVIDER INFO & PH # ()																																																	
SIGNED _____ DATE _____										a. NPI										b. NPI										a. NPI										b. NPI																													