

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



# HEALTH INSURANCE CLAIM FORM

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)            MEDICAID <input type="checkbox"/> (Medicaid #)            CHAMPUS <input type="checkbox"/> (Sponsor's SSN)            CHAMPVA <input type="checkbox"/> (VA File #)            GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)            FECA BLK LUNG <input type="checkbox"/> (SSN)            OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY    STATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY    STATE	
ZIP CODE    TELEPHONE (Include Area Code) ( )		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY    F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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 <input checked="" type="checkbox"/> DATE <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH    SEX MM   DD   YY    M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO    If yes, return to and complete Item 9 a-d.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM   DD   YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
1. _____    3. _____ 2. _____    4. _____		22. MEDICAID RESUBMISSION CODE    ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY		B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER E. DIAGNOSIS CASE F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. EMG J. COB K. RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/> <input type="checkbox"/>		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.)		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS & PHONE #			

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_