

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Sample Completed Form for Group Practices

CARRIER

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John 3. PATIENT'S BIRTH DATE MM DD YY 00 00 00 SEX M X F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John

5. PATIENT'S ADDRESS (No., Street) 123 A Street 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other 7. INSURED'S ADDRESS (No., Street) 123 A Street

CITY STATE 8. PATIENT'S CITY STATE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 11. INSURED'S POLICY GROUP OR FECA NUMBER GR0101010101

ZIP CODE TELEPHONE (Include Area Code) 11111 (111) 111-1111 11111 (111) 111-1111

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYER'S NAME OR SCHOOL NAME Main Street Employer

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M X F b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO

c. EMPLOYER'S NAME OR SCHOOL NAME National Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME 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 AND DATE 00/00/00 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) PATIENT HAS HAD SAME OR SIMILAR ILLNESS. 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 James A. Physician MD 17a. NPI 17b. NPI 0123456789 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V58.11 3. 196.0 2. 186.9 4. 78701 22. MEDICAL CODE REF. NO. 23. PRIOR

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 F. \$ CHARGES G. OR UNITS H. I. J. RENDERING PROVIDER ID. #

1 10 23 10 10 23 10 11 99213 25 1,2,3,4 85 00 1 NPI 9876543210

2 10 23 10 10 23 10 11 96413 1,2 290 00 1 NPI

3 10 23 10 10 23 10 11 96415 1,2 65 00 1 NPI

4 10 23 10 10 23 10 11 96417 1,2 141 00 1 NPI

5 10 23 10 10 23 10 11 J9206 1,2 1405 00 5 NPI

6 10 23 10 10 23 10 11 J9201 1,2 2169 00 9 NPI

25. FEDERAL EIN 4444444444 26. PATIENT'S ACCOUNT NO. 101010 28. TOTAL CHARGE \$ 4155 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 4155 00

31. SIGNATURE OF PHYSICIAN OR OTHER PROVIDER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) John Doe MD 102309 32. SERVICE FACILITY LOCATION INFORMATION Office Place 1001 Medical Rd Anytown IA 12345 33. BILLING PROVIDER INFO & PH # Office Place Provider PO Box 11111 Anytown IA 12345

SIGNED DATE a. 9876543210 b. 9876543211

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

