

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Sample Completed Form for Solo Practitioners

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input checked="" type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		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 <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 A Street		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Other <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John		7. INSURED'S ADDRESS (No., Street) 123 A Street	
CITY Anywhere STATE IA		CITY Anywhere STATE IA	
ZIP CODE 11111 TELEPHONE (Include Area Code) (111) 111-1111		ZIP CODE 11111 TELEPHONE (Include Area Code) (111) 111-1111	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER GR0101010101	
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 <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. 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.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Signature On File 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. Signature On File	
14. DATE OF CURRENT ILLNESS (First s... INJURY (Accident) PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE James A. Physician MD		17b. NPI 0123456789	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
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. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
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. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 10 23 10 10 23 10 11 99213 25 1,2,3,4 85 00 1 NPI			
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 TAX ID # EIN 444444444		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 a. 9876543210 b.	
33. BILLING PROVIDER INFO & PH # Office Place Provider PO Box 11111 Anytown IA 12345 a. 9876543211 b.			

Be sure to complete boxes 11, 11b and 11c.

Referring Provider's NPI

Complete 32 and 32a if different from 33 and 33a

Billing Provider's NPI

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION