

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER
2. PATIENT'S NAME Doe, John
3. PATIENT'S BIRTH DATE 00/00/00
4. INSURED'S NAME Doe, John
5. PATIENT'S ADDRESS 123 A Street
6. PATIENT RELATIONSHIP TO INSURED Self
7. INSURED'S ADDRESS 123 A Street
8. PATIENT STATUS Single
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER GR0101010101
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Signature On File
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Signature On File

14. DATE OF CURRENT ILLNESS OR INJURY 00/00/00
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 00/00/00
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE James A. Physician MD
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY V58 11
22. MEDICAID RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER

Table with 6 rows and 10 columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL., J. RENDERING PROVIDER ID. #

24. A. DATE(S) OF SERVICE
25. FEDERAL TAX I.D. NUMBER 444444444
26. PATIENT'S ACCOUNT NO. 101010
27. ACCEPT ASSIGNMENT? YES NO
28. TOTAL CHARGE \$ 4155 00
29. AMOUNT PAID \$
30. BALANCE DUE \$ 4155 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS John Doe MD 102309
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