Name & Address where claims are to be mailed:

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| HEALTH INSURANCE CLAIM FORMAPPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 |  |  |
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER CHAMPUS HEALTH PLAN BLK LUNG  | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1) |
| □ □ (*Medicare #)* □ *Medicaid #)* □ *(Sponsor’s SSN)* □ *(VA File #)* □ *(SSN or ID)* □ *(SSN)* □ *(ID)* |  |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT’S BIRTH DATE MM DD YY Sex | 4. INSURED’S NAME (Last Name, First Name, Middle Initial) |
|  |  |  | M□ F□ |  |
| 5. PATIENT’S ADDRESS (No. Street)  | 6. PATIENT’S RELATIONSHIP TO INSUREDSelf □ Spouse □ Child □ Other □  | 7. INSURED’S ADDRESS (No. Street) |
| CITY  |  | STATE | 8. PATIENT STATUS Single □ Married □ Other □ | CITY | STATE |
| ZIP CODE  |  | TELEPHONE (Include Area Code) |  Employed □ Full –Time □ Part-time □ Student Student | ZIP CODE  |  | TELEPHONE (Include Area Code) |
|  |  |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT’S CONDITION RELATED TO: | 11. INSURED’S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) □ YES □ NO | a. INSURED’S DATE OF BIRTH SEX MM DD YY  |
|  M□ F□  |
| b. OTHER INSURED’S DATE OF BIRTH SEX MM DD YY  | b. AUTO ACCIDENT? PLACE (STATE) □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_ | b. EMPLOYER NAME OR SCHOOL NAME |
|  M□ F□  |
| c. EMPLOYER NAME OR SCHOOL NAME | c. OTHER ACCIDENT? □ YES □ NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| 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 9a-d |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM1. 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 wither to myself or to the party who accepts assignment below.

 SIGNED\_\_\_Signature on File\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. DATE OF CURRENT:
 | ◄ | ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION |
|  MM  |  DD |  YY | GIVE FIRST DATE MM | DD | YY |  MM FROM | DD | YY MM TO | DD | YY |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   | 17a |  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |
| 17b | NPI |  |  MM FROM | DD | YY MM TO | DD | YY |
| 19. RESERVED FOR LOCAL USE  | 20. OUTSIDE LAB?  □ YES □ NO |  $ CHARGES |
|  |  |
| 21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE) | 22. MEDICAID RESUBMISSION  CODE  | ORIGINAL REF. NO. |
| 1  | 3.  |  |  |
| 2.  | 4.  | 23. PRIOR AUTHORIZATION NUMBER |
| 24. A | B | C | D | E | F | G | H | I | J | K |
| DATE(S) OF SERVICEFrom ToMM DD YY MM DD YY | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)CPT/HCPCS MODIFIER | DIAGNOSIS CODE | $ CHARGES | DAYSORUNITS | EPSDT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT’S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. BALANCE DUE |
|  |   |  | 🞎 YES ⌧ NO | **$** |  |  | **$** |  |  | **$** |  |  |
| 31. SIGNATURE OR PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the same statements on the reverse apply to this bill and are made a part thereof.) | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | 33. PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE& PHONE # |