Name & Address where claims are to be mailed:

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| HEALTH INSURANCE CLAIM FORM  APPROVED 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 INSURED  Self □ 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 FORM   1. 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 SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | Place  of Service | | Type  of Service | | | PROCEDURES, SERVICES, OR SUPPLIES  (Explain Unusual Circumstances)  CPT/HCPCS MODIFIER | | | | | | | | | | DIAGNOSIS CODE | | $ CHARGES | | | | | DAYS  OR  UNITS | | | | 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 # | | | | | | | | | | | | | | | | | | | | | |