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## **HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

	PICA		PICA T	
	I. MEDICARE MEDICAID TRICARE CHAMPV/	- HEALTH PLAN - BLK LUNG	IER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
L	(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID	O#) (SSN or ID) (SSN) (ID)	and a part of the same of the contract of the same of	
1	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	INSURED'S NAME (Last Name, First Name, Middle Initial)	
-	5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
	and the second of the first of the second of	Self Spouse Child Other	The state of the second second second second second second	
-	CITY	8. PATIENT STATUS	CITY STATE	
		Single Married Other	3858(33)	
	ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)	
	OTHER MOURENCE MANE (Local Name of State Nam	Employed Student Student		
,	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)	a. INSURED'S DATE OF BIRTH SEX	
		YES NO	MM DD YY M F	
-	O. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State	b. EMPLOYER'S NAME OR SCHOOL NAME	
	M F	YES NO	en urbailt í sellegga feilig ag senan milligett eins haldni	
(	E. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
	I. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
(	I. INSUHANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	A SECTION OF THE PROPERTY OF SECTION OF SECT	
	READ BACK OF FORM BEFORE COMPLETING	& SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize	
12. 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 either to myself or to the party who accepts assignment below.				
	SIGNED	DATE	SIGNED	
	14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	F PATIENT HAS HAD SAME OR SIMILAR ILLNES GIVE FIRST DATE MM   DD   YY	I FROM I TO I I	
	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	
	176.	. NPI	FROM TO	
	19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)  22. MEDICAID RESUBMISSION				
			22. MEDICAID RESUBMISSION ORIGINAL REF. NO.	
	1	A STANSON OF THE STAN	23. PRIOR AUTHORIZATION NUMBER	
	2	medical to a section of the energy of value of	as a construction to the state of the state	
-		DURES, SERVICES, OR SUPPLIES E. in Unusual Circumstances) DIAGNOS	F. G. H. I. J.  DAYS EPSOT ID. RENDERING	
	MM DD YY MM DD YY SERVICE EMG CPT/HCPC	CS   MODIFIER POINTE		
			NPI	
			NPI	
100			NPI NPI	
			MDI	
1			NPI NPI	
			NPI	
		A STATE OF THE STA	NPI NPI	
-	25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt. claims, see back)		
	A CIONATURE OF PHYCICIAN OR CURRULED 20 SERVICE FA	CILITY LOCATION INFORMATION	\$ \$ \$ \$ 33. BILLING PROVIDER INFO & PH # (	
	INCLUDING DEGREES OR CREDENTIALS	SILIT LOCATION INFORMATION	SS. DIELING PROVIDER IN CAPITA	
	(I certify that the statements on the reverse apply to this bill and are made a part thereof.)			
	minutes and high an interesting condens. The first water		na at site sa antigo of Saks a Inda Alamane é acte is an alamane de la company de la c	
	SIGNED DATE a.	b.	a.   a.	