

MDCodeWizard.com

HEALTH INSURANCE CLAIM FORM

APPROVED BY I	ΝΑΤΙΟΝΙΑΙ	LIMITEDEM	CL AIM CC	MANAITTEE.	(NILICC)	02/12

PICA			PICA		
. MEDICARE MEDICAID TRICARE CHAMPV (Medicare #) (Medicaid #) (ID#/DoD#) (Member	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)		
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM D YY M F	4. INSURED'S NAME (Last Name, First Name)	ame, Middle Initial)		
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)			
TY STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	CITY STATE			
P CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPI	HONE (Include Area Code)		
()		()		
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FEC	CA NUMBER		
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX		
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUC	M F		
RESERVED FOR NUCC USE	YES NO	C. INSURANCE PLAN NAME OR PROGRAM NAME			
	c. OTHER ACCIDENT? YES NO				
NSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes , complete items 9, 9a and 9d.			
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either	e release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSO	ON'S SIGNATURE I authorize		
below. SIGNED	DATE	SIGNED			
MM DD YY ' '	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO YY			
NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 71b	ı. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO			
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ YES NO	CHARGES		
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	ervice line below (24E) ICD Ind.	22 RESURMISSION	IAL REF. NO.		
B C F G	D. [H. [23. PRIOR AUTHORIZATION NUMBER			
J. K. A. DATE(S) OF SERVICE B. C. D.PROC	EDURES, SERVICES, OR SUPPLIES E.		J. J.		
	plain Unusual Circumstances) DIAGNOSIS	DAYS EPSDT	ID. RENDERING UAL. PROVIDER ID. #		
		[1	NPI		
			NPI		
			NPI		
		1	NPI		
		1 1	NPI		
			NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE 29. AMOUN	1		
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	ACILITY LOCATION INFORMATION	\$ \$ 33. BILLING PROVIDER INFO & PH #	()		
GNED DATE a.	b.	a. b.			