



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE ☐ (Medicare #)		MEDICAID ☐ (Medicaid #)	
TRICARE ☐ (ID#/DoD#)		CHAMPVA ☐ (Member ID#)	
GROUP HEALTH PLAN ☐ (ID#)		FECA BLK LUNG ☐ (ID#)	
OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (Include Area Code) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO c. OTHER ACCIDENT? ☐ YES ☐ NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a and 9d.	
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 _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____		15. OTHER DATE MM DD YY QUAL. _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER	
F. \$ CHARGES		G. DAYS OR UNITS	
H. EPSDT Family Plan		I. ID. QUAL.	
J. RENDERING PROVIDER ID. #			
1		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. 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. AMOUNT PAID \$		30. Rsvd for NUCC use	
31. 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.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____	
33. BILLING PROVIDER INFO & PH. # () a. NPI b. _____			