

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/... 2. PATIENT'S NAME 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME 5. PATIENT'S ADDRESS 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS 8. PATIENT STATUS 9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO... 11. INSURED'S POLICY GROUP OR FECA NUMBER 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 14. DATE OF CURRENT ILLNESS 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS 16. DATES PATIENT UNABLE TO WORK 17. NAME OF REFERRING PROVIDER 18. HOSPITALIZATION DATES 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS 22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER 24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT/Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.# 25. FEDERAL TAX I.D. NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #