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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

 Attn: Claims Department
 P.O. Box 29130
 Hot Springs, AR 71903

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| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small> | | 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 <input type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERVED FOR LOCAL USE | |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. | | | |
| 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. | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| SIGNED _____ DATE _____ | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | | b. EMPLOYER'S NAME OR SCHOOL NAME | |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. | |
| 17a. NPI | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| 19. RESERVED FOR LOCAL USE | | SIGNED _____ | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| 1. _____ 3. _____ | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 2. _____ 4. _____ | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES | |
| 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 | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | 23. PRIOR AUTHORIZATION NUMBER | |
| 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28. TOTAL CHARGE \$ | | 29. AMOUNT PAID \$ | |
| 30. BALANCE DUE \$ | | 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.) | |
| 32. SERVICE FACILITY LOCATION INFORMATION | | 33. BILLING PROVIDER INFO & PH. # () | |
| SIGNED _____ DATE _____ | | a. _____ b. _____ | |