

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

Attn: Claims Department

P.O. Box 29130

Hot Springs, AR 71903

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID#)										GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (SSN) <input type="checkbox"/> (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 SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		CITY		STATE	
ZIP CODE					TELEPHONE (Include Area Code) ()					ZIP CODE		TELEPHONE (Include Area Code) ()			
9. 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 b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME			
										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9-a-d.</i>			
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.										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 _____ DATE _____			
SIGNED _____					DATE _____					SIGNED _____					
14. DATE OF CURRENT: MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY					
ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					FROM _____ TO _____					FROM _____ TO _____					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY					
17b. NPI					17b. NPI					FROM _____ TO _____					
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)			
1. _____					3. _____					22. MEDICAID RESUBMISSION CODE _____		ORIGINAL REF. NO. _____			
2. _____					4. _____					23. PRIOR AUTHORIZATION NUMBER _____					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER F. DIAGNOSIS MODIFIER G. POINTER H. \$ CHARGES I. DAYS OR UNITS J. EPDS/ Family Plan L. ID. QUAL. K. RENDERING PROVIDER ID. # L. NPI															
1. _____										NPI					
2. _____										NPI					
3. _____										NPI					
4. _____										NPI					
5. _____										NPI					
6. _____										NPI					
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/>					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. _____			a. _____ b. _____							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV