



HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																			
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane					3. PATIENT'S BIRTH DATE MM DD YY 06 10 1981 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 901 East Street					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY Texas City			STATE TX		8. RESERVED FOR NUCC USE					CITY			STATE																
ZIP CODE 78218			TELEPHONE (Include Area Code) (210) 555-1234							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					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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. Signature on File 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. Signature on File SIGNED _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 04 2015 QUAL. _____					15. OTHER DATE QUAL. _____ MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. Z3401 B. O80 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER 1234567890																			
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #									
From MM DD YY To MM DD YY		SERVICE				CPT/HCPCS MODIFIER																							
1 01 01 2016 01 01 2016		1				99211 TH				A		22.80						NPI											
2 01 02 2016 01 02 2016		2				59410				A		700.00						NPI											
3																		NPI											
4																		NPI											
5																		NPI											
6																		NPI											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 12345					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 722.80					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.) Alicia Thomas CNM 01/17/2016 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION Sisters of Mercy Hospital 1242 Bogen Blvd. Texas City, TX 77592 a. 4302198765 b. _____										33. BILLING PROVIDER INFO & PH # () Alicia Thomas, CNM 184 Marron Dr Texas City, TX 77592 a. 9876543021 b. 1234567-01									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION