



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 05 27 1992 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) 422 Pine 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 Laredo					STATE TX					8. RESERVED FOR NUCC USE										CITY					STATE																			
ZIP CODE 79701					TELEPHONE (Include Area Code) (209) 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 (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE															b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE															c. OTHER ACCIDENT? <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. SIGNED _____																													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 12 29 2016 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 BJ Higgins Martinez MD															17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI _____															17c. _____ 1234567089																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. J953 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____															22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER 123456789																			
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. #																							
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER				\$																																
01	01	2016	01	07	2016	2	99503				1	466.76	A					NPI																										
01	12	2016	01	12	2016	2	99503				1	1111.26	A					NPI																										
01	16	2016	01	16	2016	2	99503				1	66.68	A					NPI																										
01	20	2016	01	20	2016	2	99503				1	66.68	A					NPI																										
01	21	2016	01	21	2016	2	99503				1	854.15	A					NPI																										
01	21	2016	01	21	2016	2	99503				1	854.15	A					NPI																										
01	21	2016	01	21	2016	2	99503				1	854.15	A					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 \$ 2565.53					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.) Julie Harris RCP SIGNED _____ DATE 01 24 2016															32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____															33. BILLING PROVIDER INFO & PH # () Julie Harris RCP 1204 East Ave. Laredo, TX 78041 a. 9876543021 b. 1234567-01														

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION