



# 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) <b>123456789</b>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, Jane</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>06 01 2018</b> 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) <b>5432 West Main St.</b>					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 <b>Star</b>			STATE <b>TX</b>		8. RESERVED FOR NUCC USE					CITY			STATE																
ZIP CODE <b>77787</b>			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					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 checked="" 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. 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    QUAL. _____					15. OTHER DATE MM DD YY    QUAL. _____					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 _____					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. <b>0</b>										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																			
A. <b>Z00121</b> B. <b>Z23</b> C. _____    D. _____										23. PRIOR AUTHORIZATION NUMBER _____																			
E. _____    F. _____    G. _____    H. _____																													
I. _____    J. _____    K. _____    L. _____																													
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 08 05 2018 08 05 2018		1 NU		G8510 SA				A		20.00		1				NPI													
2 08 05 2018 08 05 2018		1 NU		99381 SA 25				A		100.00		1				NPI													
3 08 05 2018 08 05 2018		1 NU		90743 SA				B		0.01						NPI													
4 08 05 2018 08 05 2018		1 NU		90471 SA				B		8.00						NPI													
5 08 05 2018 08 05 2018		1 NU		90698 SA				B		0.01						NPI													
6 08 05 2018 08 05 2018		1 NU		90472 SA				B		8.00						NPI													
25. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>136.02</b>					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.)  <b>Signature on File    01 01 2018</b> SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b. _____										33. BILLING PROVIDER INFO & PH # <b>( 512 ) 555-1234</b> <b>Star Community Health Center</b> <b>100 Main St.</b> <b>Star, TX 77777</b> a. <b>9876543021</b> b. <b>1234567-01</b>									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION