



HEALTH INSURANCE CLAIM FORM

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

☐ PICA										☐ PICA																																																	
1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (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 MM DO YY SEX M ☐ F ☐										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐										7. INSURED'S ADDRESS (No., Street)																																							
CITY					STATE					8. RESERVED FOR NUCC USE					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:					11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐					b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) _____					c. OTHER ACCIDENT? YES ☐ NO ☐					10a. CLAIM CODES (Designated by NUCC)																								
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 _____																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DO YY QUAL _____										15. OTHER DATE MM DO YY QUAL _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DO YY TO MM DO YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DO YY TO MM DO YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17b. NPI _____										20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																	
A. _____ B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____																																																	
E. _____ F. _____ G. _____ H. _____																																																											
I. _____ J. _____ K. _____ L. _____																																																											
24. A. DATE(S) OF SERVICE From MM DO YY To MM DO YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPTHCPCS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPIC Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																																											
1																																																											
2																																																											
3																																																											
4																																																											
5																																																											
6																																																											
25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? For spec. charge, see back YES ☐ NO ☐										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Rsd 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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI b. _____										a. NPI b. _____																																							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)