1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

☐☐ PICA | PICA ☐☐

| 1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | 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 ¦ DD ¦ 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. PATIENT STATUS Single☐ Married☐ Other☐ | CITY | STATE |

| ZIP CODE | TELEPHONE (Include Area Code) ( ) | Employed☐ Full-Time Student☐ Part-Time Student☐ | 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) YES☐ NO☐ | a. INSURED'S DATE OF BIRTH MM ¦ DD ¦ YY SEX M☐ F☐ |

| b. OTHER INSURED'S DATE OF BIRTH MM ¦ DD ¦ YY SEX M☐ F☐ | b. AUTO ACCIDENT? YES☐ NO☐ PLACE (State) | b. EMPLOYER'S NAME OR SCHOOL NAME |

| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES☐ NO☐ | 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? YES☐ NO☐ If yes, return to and complete item 9 a-d. |

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM ¦ DD ¦ YY ◄ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 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 FROM ¦ ¦ TO ¦ ¦ |

| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. ¦ 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM ¦ DD ¦ YY MM ¦ DD ¦ YY FROM ¦ ¦ TO ¦ ¦ |

| 19. RESERVED FOR LOCAL USE | 20. OUTSIDE LAB? YES☐ NO☐ $ CHARGES |

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L___ . ___   3. L___ . ___

2. L___ . ___   4. L___ . ___

| 22. MEDICAID RESUBMISSION CODE ¦ ORIGINAL REF. NO. |
| 23. PRIOR AUTHORIZATION NUMBER |

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			CPT/HCPCS	MODIFIER						
1														NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

| 25. FEDERAL TAX I.D. NUMBER SSN☐ EIN☐ | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES☐ 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.) SIGNED _____ DATE _____ | 32. SERVICE FACILITY LOCATION INFORMATION a. ¦ b. | 33. BILLING PROVIDER INFO & PH # ( ) a. ¦ b. |

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