

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



APPROVED OMB-0938-0003

CARRIER

**HEALTH INSURANCE CLAIM FORM**

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																								
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					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 <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																								
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)  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: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME																								
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					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 _____					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					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: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																																		
1. _____ 3. _____ 2. _____ 4. _____																																		
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE <small>MM DD YY MM DD YY CPT/HCPCS MODIFIER</small>																																		
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #  PIN# _____ GRP# _____														

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/83)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,