



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1 2 3 4 5 6

TRGA										FICA	
1 MEDICARE: MEDICARE (Medicare #) <input type="checkbox"/> MEDICALLY NECESSARY (Medically #) <input type="checkbox"/> TRICARE CHAMPVA (Tricare/Champva/Spouse's TRM) <input type="checkbox"/> CHAMPVA (Member Care) <input type="checkbox"/> GROUP HEALTH PLAN (Group or ID) <input type="checkbox"/> FECA (FECA/UMIA/USRA) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										16 INSURED'S I.D. NUMBER (For Program in Part 1) 123456789	
2 PATIENT'S NAME (Last, First, Middle Initial) BEACH, SANDY				3 PATIENT'S BIRTH DATE 01 05 1960		4 INSURED'S NAME (Last, First, Middle Initial) BEACH, SANDY					
5 PATIENT'S ADDRESS (No. & St.) 123 BEACH VIEW				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. & St.)					
CITY ANY BEACH		STATE VA		8 PATIENT STATUS: Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE 23462		TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code) ()			
9 OTHER INSURED'S NAME (Last, First, 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)		12 INSURED'S DATE OF BIRTH MM DD YY M F		SEX: M <input type="checkbox"/> F <input type="checkbox"/>			
b OTHER INSURED'S DATE OF BIRTH MM DD YY M F				b AUTO-ACCIDENT?		13 EMPLOYER'S NAME OR SCHOOL NAME					
c EMPLOYER'S NAME OR SCHOOL NAME				c OTHER ACCIDENTS?		14 INSURANCE PLAN NAME OR PROGRAM NAME					
d INSURANCE PLAN NAME OR PROGRAM NAME				15 IS THERE ANOTHER HEALTH-BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, list in and on reverse side of card</i>		16 IS THERE ANOTHER HEALTH-BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 17 PATIENT 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 benefit to which I am entitled to the party who accepts assignment below.)											
SIGNED: SIGNATURE ON FILE						SIGNED: SIGNATURE ON FILE					
DATE: 07/01/2007						DATE:					
14 DATE OF CURRENT ILLNESS (First episode) OR INJURY (Accident) OR PREGNANCY 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 PROVIDER OR OTHER SOURCE				17b NPI: 123456789				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19 RESERVED FOR LOCAL USE				20 OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO				21 MEDICAD RESUBMISSION CODE ORIGINAL REF NO			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From ICD-9-CM 1, 2, 3 or 410-600 24E04 199)				22 PRIOR AUTHORIZATION NUMBER							
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY				B PLACE OF SERVICE ESW				C PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Cystostomy) ICD-9-CM PROCEDURE			
07 05 2007 07 05 2007				11 H0004				75 00 1			
25 FEDERAL TAX I.D. NUMBER 123456789				26 PATIENT'S ACCOUNT NO. 12345				27 ACCEPT ASSIGNMENT? (Patient's Signature) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
28 SIGNATURE OF PHYSICIAN OR SUPPLIER (M.D., D.O., DENTIST, OR CREDENTIALS. If entity that the statements on file involve apply to this bill and are made a part thereof.) PROVIDER SIGNATURE				29 SERVICE FACILITY LOCATION INFORMATION SERVICING STREET ADDRESS CITY, STATE ZIP CODE				30 TOTAL CHARGE: \$ 75 00			
31 SERVICE FACILITY LOCATION INFORMATION PAYMENT ADDRESS CITY, STATE ZIP CODE				32 BALANCE DUE: \$				33 AMOUNT PAID: \$			
34 SIGNATURE OF PHYSICIAN OR SUPPLIER (M.D., D.O., DENTIST, OR CREDENTIALS. If entity that the statements on file involve apply to this bill and are made a part thereof.) PROVIDER SIGNATURE				35 SERVICE FACILITY LOCATION INFORMATION SERVICING STREET ADDRESS CITY, STATE ZIP CODE				36 TOTAL CHARGE: \$ 75 00			
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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

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