



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 7865436									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PARKER, ROSS										3. PATIENT'S BIRTH DATE MM DD YY SEX 06 06 2013 M <input checked="" type="checkbox"/> <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ALBANY OR 97321 (541) 5552222										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/> 8. RESERVED FOR NUCC USE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 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										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. 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. SIGNED SOF DATE 06/18/2014										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d. 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 SOF									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 06 18 2014										15. OTHER DATE MM DD YY QUAL. 06 18 2014									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SEYMOUR KOFFS DO										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 06 18 2014 06 18 2014									
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. 9 A. 81306 B. C. D. 9 E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID, QUAL. J. RENDERING PROVIDER ID. #																			
1 06 18 14 06 18 14 11 99212 A 65 00 1 NPI 2313890																			
2 06 18 14 06 18 14 11 73090 A 96 00 1 NPI 231890																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 4217890908 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 678									
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.) SOF SIGNED DATE 06/19/2014										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 32. SERVICE FACILITY LOCATION INFORMATION ACUMEN MEDICAL PRACTICE 791 NORTH LANE SOMEWHERE OR 12345 a. X100X1000 b.									
33. BILLING PROVIDER INFO & PH # (555) 8888888 ACUMEN MEDICAL PRACTICE 791 NORTH LANE SOMEWHERE OR 12345 a. X100X1000 b.										28. TOTAL CHARGE \$ 161 00 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use									