# HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

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): 333333333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MILLER, NOAH

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1984 SEX M ☑ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KEYSTONE METAL WORKS

5. PATIENT'S ADDRESS (No., Street): 3072 VIEW LANE

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☑

7. INSURED'S ADDRESS (No., Street): 6500 PACIFIC BLVD

CITY: ALBANY STATE: OR

8. RESERVED FOR NUCC USE

CITY: ALBANY STATE: OR

ZIP CODE: 97321 TELEPHONE (Include Area Code): (555) 5555555

ZIP CODE: 97321 TELEPHONE (Include Area Code): (555) 5555556

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. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? ☐ YES ☑ NO PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? ☐ YES ☑ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☑ NO *If yes*, complete items 9, 9a, and 9d.

**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 SOF 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 SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 18 14 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 04 18 14 TO 05 15 14

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SEYMOUR KOFFS DO

17a.

17b. NPI 231890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☑ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. M5126 B. C. D. 0

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 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 | 04 | 18 | 14 | 04 | 18 | 14 | 11 | | 99202 | | A | 190 00 | 1 | | NPI | 231890 |
| 2 | | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☑: 42123987456

26. PATIENT'S ACCOUNT NO.: 045678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☑ YES ☐ NO

28. TOTAL CHARGE: $ 190 00

29. AMOUNT PAID: $

30. Rsvd 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.)

SOF

SIGNED DATE 04/19/2014

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.

PATIENT AND INSURED INFORMATION