



HEALTH INSURANCE CLAIM FORM

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

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 7865436	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY 06 06 2013 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) PARKER, ROSS		7. INSURED'S ADDRESS (No., Street) 23 INDIANA ROAD	
CITY	STATE	CITY	STATE
ALBANY	OR	ALBANY	OR
ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
	()	97321	(541) 5552222
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	

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**

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		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 SEYMOUR KOFFS DO		17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17b. NPI 2313890		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____		A. 81306		22. RESUBMISSION CODE ORIGINAL REF. NO.	
B. _____		C. _____		23. PRIOR AUTHORIZATION NUMBER	
E. _____		F. _____		G. _____	
I. _____		J. _____		H. _____	
L. _____		K. _____		L. _____	

24. A. DATE(S) OF SERVICE	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. #
06 18 14 06 18 14 11	11		99212	A	65 00	1		NPI	2313890
06 18 14 06 18 14 11	11		73090	A	96 00	1		NPI	231890
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER 4217890908		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 678		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 161 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				32. SERVICE FACILITY LOCATION INFORMATION ACUMEN MEDICAL PRACTICE 791 NORTH LANE SOMEWHERE OR 12345				33. BILLING PROVIDER INFO & PH # (555) 8888888 ACUMEN MEDICAL PRACTICE 791 NORTH LANE SOMEWHERE OR 12345							
SIGNED				DATE 06/19/2014				a. X100X1000		b.		a. X100X1000		b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION