Support

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA Prints Text Only - For use with pre-printed forms

ABC INSURANCE COMPANY
SUITE 800
567 INSURANCE LANE
BIG CITY, IL 60605

CARRIER

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X0123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FILLABLE DEMO - TYPE HERE & SAVE

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1988 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE JOHN J

5. PATIENT'S ADDRESS (No., Street): FOR USE WITH ADOBE READER

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 MAIN STREET

CITY: ANYTOWN STATE: IL

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY: ANYTOWN STATE: IL

ZIP CODE: 60610 TELEPHONE (Include Area Code): (888) 5551212

ZIP CODE: A1234 TELEPHONE (Include Area Code): (888) 5551212

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): DOE MARY J

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: A1234

a. OTHER INSURED'S POLICY OR GROUP NUMBER: X9876543210

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM 01 DD 01 YY 1958 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM 11 DD 11 YY 1960 SEX M [ ] F [X]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: LOCAL COMPANY

c. EMPLOYER'S NAME OR SCHOOL NAME: COMMUNITY HOSPITAL

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC INSURANCE COMPANY

d. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ INSURANCE COMPANY

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

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 SIGNATURE ON FILE DATE 9/25/2011

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM 09 DD 30 YY 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM 09 DD 25 YY 2011

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM 09 DD 25 YY 2011 TO MM 10 DD 28 YY 2011

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JANE A SMITH MD

17a. 1G ABC1234567890

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM 09 DD 25 YY 2011 TO MM 09 DD 28 YY 2011

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 998.59
2. 780.6
3. 718.0
4. E87.88

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22. MEDICAID 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 One time purchase charge - Create Unlimited Claims/Templates										1B	Z5678901234
09 30 11	09 30 11	11	Y	99241	25	1234	90 00	1.5	Y	NPI	9876543210
2 Purchase the form with optional calculations (seen here)											12345678901
10 01 11	01 01 11	11	N	A6410	P2	13	45 00	1	N	NPI	0123456789
3 Install on up to 2 computers such as home and office										NPI	
4 Discounts available for multiple users										NPI	
5 Use with either PC or Mac										NPI	
6 If not aligned properly with your printer click here for adjustment options										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12341234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ 135 00

29. AMOUNT PAID $ 10 00

30. BALANCE DUE $ 125 00

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. SERVICE FACILITY LOCATION INFORMATION
PHYSICIAN PRACTICE INC
1234 HEALTHCARE STREET
ANYTOWN IL 60610-1234
a. 9876543210 b. 1BZ5678901234

33. BILLING PROVIDER INFO & PH # (312) 5552222
PHYSICIAN PRACTICE INC
1234 HEALTHCARE STREET
ANYTOWN IL 60610-1234
a. 9876543210 b. 1BZ5678901234

Calculation adds up charges 1-6 in 24F for Total Charge in 28. Calculations Off Calculate Now Clear Form