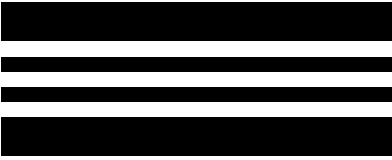


PLEASE DO NOT STAPLE IN THIS AREA



CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY M F SEX	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F SEX		a. INSURED'S DATE OF BIRTH MM DD YY M F SEX	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d</i>	
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 _____ 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 _____	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First Symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
1. . 3.		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$CHARGES _____	
2. . 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO	
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE		23. PRIOR AUTHORIZATION NUMBER	
1		F \$CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE	
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
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 _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		28. TOTAL CHARGE \$ _____	
		29. AMOUNT PAID \$ _____	
		30. BALANCE DUE \$ _____	
		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____	