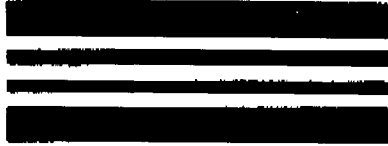


PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM										PICA			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <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			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		SEX M <input type="checkbox"/> F <input type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			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>					
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.						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 _____						SIGNED _____							
14. DATE OF CURRENT: MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
1. _____ 2. _____ 3. _____ 4. _____						23. PRIOR AUTHORIZATION NUMBER							
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	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COR	K RESERVED FOR LOCAL USE
25. FEDERAL TAX I.D. NUMBER		SSN EIN		28. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		26. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$
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.)						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
SIGNED _____						DATE _____			PIN# _____		GRP# _____		