HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) **X**

1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789A**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Doe, John**

3. PATIENT'S BIRTH DATE MM DD YY: **01 11 1949** SEX M **X** F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): **Doe, Susan**

5. PATIENT'S ADDRESS (No., Street): **123 Main Street**

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

7. INSURED'S ADDRESS (No., Street): **123 Main Street**

CITY: **Anytown** STATE: **NY**

8. RESERVED FOR NUCC USE

CITY: **Anytown** STATE: **NY**

ZIP CODE: **10001** TELEPHONE (Include Area Code): ( )

ZIP CODE: **10001** TELEPHONE (Include Area Code): ( )

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 _____ 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: **DN Marcus Welby**

17a.

17b. NPI **1245319599**

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

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. **E11.9** B. **E78.5** C. D.

E. F. G. H.

I. J. K. L.

22. 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	4 08 20		4 08 20			11		97802		AB	200 00	4		NPI	9876543219
2	4 29 20		4 29 20			11		97803		A	90 00	2		NPI	9876543219
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: **36-1234567** **X**

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 290 00

29. AMOUNT PAID $ 0 00

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.)

Mary Smith **04/29/2020**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Mary Smith, RDN, CDN
1 Central Avenue
Anytown, NY 10001

a. NPI b.

33. BILLING PROVIDER INFO & PH # (212) 555-4321

Mary Smith, RDN, CDN
1 Central Avenue
Anytown, NY 10001

a. 9876543219 b. 11