HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE  |  MEDICAID  |  TRICARE  |  CHAMPVA  |  GROUP HEALTH PLAN  |  FECA DU-LONG  |  OTHER

   Medicare #  |  Medicaid #  |  CHAMPVA #  |  Sponsor’s SSN  |  Member #  |  SSN  |  ID  \\

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

CITY  |  STATE

8. PATIENT STATUS

Single  |  Married  |  Other

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

   b. OTHER INSURED'S DATE OF BIRTH

   c. EMPLOYER'S NAME OR SCHOOL NAME

   d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OR FECA NUMBER

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.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

14. DATE OF ONSET: 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  |  TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:

FROM  |  TO

20. OUTSIDE LAB?

   22. MEDICAID RE-INVOICE CODE

   23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

   From  |  To

25. FEDERAL TAX I.D. NUMBER

   SSN  |  EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

   YES  |  NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (attach all required documentation)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & P#:

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org

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