

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0028492985	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAMPS, GALE		3. PATIENT'S BIRTH DATE MM DD YY 07 17 1969 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1 MEDICAID ST		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY DEWITT STATE MI		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CHAMPS, GALE	
7. INSURED'S ADDRESS (No., Street) 1 MEDICAID ST		CITY DEWITT STATE MI	
ZIP CODE 48820 TELEPHONE (Include Area Code) (517) 668-9999		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input checked="" type="checkbox"/>	
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		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 06 28 1969 SEX	
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 02/19/2009		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 SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 02 08 2005		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SMITH MD, JOE		17a. <input type="checkbox"/> 17b. NPI 1234567890	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 616 . 10 3. _____ 2. 599 . 0 4. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
		23. PRIOR AUTHORIZATION NUMBER 23D0522568	
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		01 15 08 11 N 99213 1 60 00 1 NPI 1234567890	
2		01 15 08 11 N 81002 2 7 00 1 NPI 1234567890	
3		01 15 08 11 N 87210 1 12 00 1 NPI 1234567890	
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER 388528528 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 12121212	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 79 00	
29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ 79 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.) SMITH MD, JOE 02/19/2009 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____	
		33. BILLING PROVIDER INFO & PH # () MDCH FAMILY HEALTH 320 S WALNUT LANSING, MI 48913 a 1519659652 b. _____	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION