

PLEASE DO NOT STAPLE IN THIS AREA

Medicare P.O. Box 830140 Birmingham, AL 35283-0140

HEALTH INSURANCE CLAIM FORM

PICA PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED

CITY STATE 8. PATIENT STATUS

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. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS)

b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT? PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT?

d. INSURANCE PLAN NAME OR PROGRAM NAME 10 d.

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.

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN

19. 20. OUTSIDE LAB? \$ CHARGES

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.

23. PRIOR AUTHORIZATION NUMBER

Table with columns A through K: DATE(S) OF SERVICE, PLACE OF SERVICE, TYPE OF SERVICE, PROCEDURES, SERVICES, OR SUPPLIES, DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSTD Family Plan, EMG, COB, RESERVED FOR LOCAL USE.

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

28. 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 #