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**CARRIER**

**HEALTH INSURANCE CLAIM FORM**

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

PICA

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

PICA

1. PATIENT’S NAME (Last Name, First Name, Middle Initial)
2. PATIENT’S BIRTH DATE

MM DD YY

M

SEX

OTHER

*(ID#)*

F

1a. INSURED’S I.D. NUMBER (For Program in Item 1)

4. INSURED’S NAME (Last Name, First Name, Middle Initial)

1. PATIENT’S ADDRESS (No., Street)

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

1. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

8. RESERVED FOR NUCC USE

7. INSURED’S ADDRESS (No., Street)

CITY STATE

**PATIENT AND INSURED INFORMATION**

ZIP CODE TELEPHONE (Include Area Code)

# ( ) ( )

1. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)
2. IS PATIENT’S CONDITION RELATED TO:
3. INSURED’S POLICY GROUP OR FECA NUMBER
   1. OTHER INSURED’S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)

YES NO

1. INSURED’S DATE OF BIRTH

MM DD YY

SEX

M F

1. RESERVED FOR NUCC USE

b. AUTO ACCIDENT?

PLACE (State)

1. OTHER CLAIM ID (Designated by NUCC)
2. RESERVED FOR NUCC USE
3. INSURANCE PLAN NAME OR PROGRAM NAME

YES NO

c. OTHER ACCIDENT?

YES NO

10d. RESERVED FOR LOCAL USE

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

1. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
2. OTHER DATE

MM DD YY

1. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

MM DD YY MM DD YY

QUAL. QUAL.

1. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.

71b. NPI

FROM TO

1. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

MM DD YY MM DD YY

FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES

1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)

ICD Ind.

YES NO

1. RESUBMISSION

CODE ORIGINAL REF. NO.

* 1. B.

E. F.

I. J.

**PHYSICIAN OR SUPPLIER INFORMATION**

C. D.

G. H.

K. L.

1. PRIOR AUTHORIZATION NUMBER
2. A.

DATE(S) OF SERVICE

B. C.

D.PROCEDURES, SERVICES, OR SUPPLIES E.

F. G.

H. I. J.

From

To PLACE OF

(Explain Unusual Circumstances)

DIAGNOSIS

DAYS OR

EPSDT

Family

ID.

RENDERING

MM DD YY

# 1

2

3

4

5

6

MM DD YY

SERVICE

EMG

CPT/HCPCS

MODIFIER

POINTER

$ CHARGES

UNITS

Plan

QUAL.

### NPI NPI NPI NPI NPI

NPI

PROVIDER ID. #

1. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT’S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?

(For govt. claims, see back)

* 1. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

YES NO $ $ $

* + 1. 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.)

SIGNED DATE

* + 1. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ( )

a. b. a. b.

[NUCC Instruction Manual available at: www.nucc.org](http://www.nucc.org/)

***PLEASE PRINT OR TYPE***

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