

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED										7. INSURED'S ADDRESS (No., Street)									
CITY										8. PATIENT STATUS										CITY									
STATE										Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										STATE									
ZIP CODE										Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>										ZIP CODE									
TELEPHONE (Include Area Code)										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										TELEPHONE (Include Area Code)									
()										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)										a. INSURED'S DATE OF BIRTH									
b. OTHER INSURED'S DATE OF BIRTH										<input type="checkbox"/> YES <input type="checkbox"/> NO										MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										b. AUTO ACCIDENT?										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE										<input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)										c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S SIGNATURE										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE										SIGNED									
14. DATE OF CURRENT ILLNESS										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY										DATE										FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB?										FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS										21. NPI of Referring Provider										21. Rendering Provider's Qualifier									
1. Field 17b.										2. Field 17b.										Field 17b.									
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE										C. EMG									
From MM DD YY To MM DD YY										D. PROCEDURES, SERVICES, OR SUPPLIES										E. F. G. H. I. J.									
1										24J. 1-6										NPI									
2										3										NPI									
3										4										NPI									
4										5										NPI									
5										6										NPI									
6										25. FEDERAL TAX I.D. NUMBER										25. ASSIGNMENT									
25. Facility Qualifier & ID										25. SSN										25. YES <input type="checkbox"/> NO <input type="checkbox"/>									
25. MUST include TAX ID Number										25. Facility Qualifier & ID										25. NPI of Billing Provider or Group									
25. (no qualifier needed in this field)										25. Not to be reported effective 5/23/08.										25. Field 33a.									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #									
31. NPI of Service Facility										32. a. NPI										33. a. NPI									
31. Field 32a.										32. a. NPI										33. a. NPI									
SIGNED										DATE										Ensure Use of Correct Form									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1 Billing Provider's Name, Address, State & Zip matching vendor information on contract												2 Pay to: Name, Address, State & Zip if different from field 1												3 PAT CNTL #		4 TYPE OF BILL																																																																																																																																																																																																																																																																																																																																													
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8 PATIENT NAME						9 PATIENT ADDRESS						10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACDT STATE		30																																																																																																																																																																																																																																																																																																																			
31 OCCURRENCE DATE				32 OCCURRENCE DATE				33 OCCURRENCE DATE				34 OCCURRENCE DATE				35 CODE				36 OCCURRENCE FROM				37 THROUGH				38 OCCURRENCE FROM				39 THROUGH				40 OCCURRENCE FROM				41 THROUGH				42				43				44				45				46				47				48				49																																																																																																																																																																																																																																																																																															
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42 REV CD												43 DESCRIPTION												44 HCPCS / RATE / HIPPS CODE												45 SERV DATE												46 SERV UNITS												47 TOTAL CHARGES												48 NON-COVERED CHARGES												49																																																																																																																																																																																																																																																																																			
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50 PAYER NAME												51 HEALTH PLAN												52 INFO												53 BEN												54												55												56 NPI												57 OTHER PRV ID												58 INSURANCE GROUP NO.																																																																																																																																																																																																																																																																							
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63 TREATMENT AUTHORIZATION CODES												64 DOCUM												65 EMPLOYER NAME												66												67												68												69												70												71												72												73												74												75												76												77												78												79																																																																																																																																																																							
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MUST include TAX ID Number

Billing Provider ID
Not to be reported, effective 5/23/08

NPI of Billing Provider
Field 56 NPI

Billing Provider NPI Taxonomy
Field Other

Billing Provider ID
Not to be reported, effective 5/23/08

71 PPS Code
Enter DRG Code

Attending NPI / Qual. / ID
Field 76

Ensure use of correct form

81 CC Taxonomy Codes corresponding to fields 76-79

Operating NPI / Qual. / ID
Field 77

Other NPI / Qual. / ID
Fields 78-79