HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA [ ] OTHER [ ]
   - (Medicare) [ ] (Medicaid) [ ] (TRICARE) [ ] (CHAMPVA) [ ] (Group Health Plan) [ ] (FECA) [ ] (Other) [ ]

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

3. PATIENT'S BIRTH DATE [ ]
   - (Month) [ ] (Day) [ ] (Year) [ ]

4. PATIENT'S SEX [ ]
   - (Male) [ ] (Female) [ ]

6. PATIENT'S RELATIONSHIP TO INSURED [ ]
   - (Self) [ ] (Spouse) [ ] (Child) [ ] (Other) [ ]

8. RESERVED FOR NUCC USE [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [ ]

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER [ ]

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE [ ]

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE [ ]

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) [ ]
   - (Month) [ ] (Day) [ ] (Year) [ ]

15. OTHER DATE [ ]
   - (Month) [ ] (Day) [ ] (Year) [ ]

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION [ ]
   - (Month) [ ] (Day) [ ] TO (Month) [ ] (Day) [ ]

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [ ]
   - (First Name) [ ] (Middle Name) [ ] (Last Name) [ ]
   - (NPI) [ ]

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [ ]

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY [ ]
   - (ICD-10 Code) [ ]

22. REIMBURSEMENT CODE [ ]

23. PRIOR AUTHORIZATION NUMBER [ ]

24. A. DATE(S) OF SERVICE [ ]
   - (Month) [ ] (Day) [ ] TO (Month) [ ] (Day) [ ]

25. FEDERAL TAX ID NUMBER [ ]

26. PATIENT'S ACCOUNT NO. [ ]

27. ACCEPT ASSIGNMENT? [ ]
   - (Yes) [ ] (No) [ ]

28. TOTAL CHARGE [ ]

29. AMOUNT PAID [ ]

30. Resvd for NUCC Use [ ]

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS [ ]

32. SERVICE FACILITY LOCATION INFORMATION [ ]

33. BILLING PROVIDER INFO [ ]

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)