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## **HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

	PICA																				PICA
_	MEDICARE (Medicare #)		DICAID	TR CH (Sr	RICARE HAMPUS Hoonsor's S	SN) [	CHAMF (Membe	_	GRO HEAL (SSN	UP _TH PLAI ' or ID)	N I BI	ECA LK LUNG SSN)	OTHER	1a. INSURED	'S I.D. NU	MBER			(For	Program	in Item 1)
	ATIENT'S NA	<u> </u>		<u>ш`.</u>			(Wiembe		ATIENT'S				SEX	4. INSURED'S	S NAME (L	ast Nam	ie, First N	Name, I	Middle	Initial)	
. P/	ATIENT'S AD	ODRESS	(No Stre	act)							N ONSHIP T		F L	7. INSURED'S	SADDRES	SS (No. 9	Street)				
	THENT O'AL	DITEGO	(140., 0116	.61)						Spouse	Chile		Other	7. INCOMED	J ADDITIES	30 (140., 0	Ollecty				
ITY	,						STAT	E 8. P	ATIENT	STATUS				CITY							STATE
IP (	CODE		1.	TELEPHO	ONE (Inclu	de Area	Code)		Single	N	Married		Other	ZIP CODE			TELE	PHONE	(Inclu	de Area (	'ade)
、	,0DL			(	)	140 71104	0000)	Eı	mployed		III-Time udent		t-Time	Zii GODE			(	TIONE	)	de Area c	oue)
0	THER INSUI	RED'S NA	AME (Las	t Name, F	First Name	, Middle	Initial)	10.	IS PATIE	_	NDITION			11. INSURED	'S POLIC	GROUP	P OR FE	CA NU	MBER		
. 0	THER INSUI	RED'S PC	OLICY OF	R GROUP	NUMBER	<u> </u>		a, E	MPLOYN	MENT? (C	Current or	r Previou	ıs)	a. INSURED'S	S DATE O	F BIRTH				SEX	
. 0			, , , , , , , , , , , , , , , , , , , ,							YES	_	NO	,	MM	DD	YY		М		OLX	F
	THER INSUI	RED'S DA YY	ATE OF E	1 1	SE		_	b. A	UTO AC		_	_	LACE (State)	b. EMPLOYE	R'S NAME	OR SCH	HOOL NA	AME			
 . EN	/ MPLOYER'S	NAME O	R SCHO	OL NAME		F			THER A	CCIDENT	_	NO		c. INSURANC	E PLAN N	IAME OF	R PROGE	RAM N	AME		
		0						0.0		YES		NO				2 01					
. IN	SURANCE F	PLAN NA	ME OR P	ROGRAM	I NAME			10d	. RESER	VED FOR	R LOCAL	USE		d. IS THERE							
			READ B	ACK OF I	FORM BE	FORE C	OMPLETI	NG & SI	IGNING 1	THIS FOR	RM.			13. INSURED						•	em 9 a-d. uthorize
to	PATIENT'S C process this elow.	OR AUTHO	ORIZED I	PERSON'	S SIGNAT	TURE 1	authorize th	ne releas	se of any i	medical o	or other inf				of medical	benefits t					supplier for
S	SIGNED								DA	TE				SIGNED	)						
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)						5. IF PA GIVE	TIENT H. FIRST D	AS HAD ATE M	SAME OI		AR ILLNESS. YY	MM DD YY MM DD YY									
7. N	NAME OF RE	EFERRIN			` '	OURCE	1	7a.						18. HOSPITA	LIZATION M , DD	DATES	RELATE Y	D TO C	URRE	INT SER\	/ICES YY
ο Ε	RESERVED	EOR LOC	'AI IICE				1	7b. NP	1					FROM 20. OUTSIDE		<u> </u>		ТО	HARGE	i i	
J. 1	ILOLITVLD	1011200	AL OOL											YES		NO		ΨΟι	IAITOL		
1. [	DIAGNOSIS	OR NATU	JRE OF I	LLNESS (	OR INJUR	Y (Relat	e Items 1,	2, 3 or 4	to Item 2	24E by Li	ine)		$\exists$	22. MEDICAII CODE	D RESUBN	NISSION	ORIGIN	NAL RE	F. NO		
1. L								3			-		<b>Y</b>	23. PRIOR AI	JTHORIZA	ATION NU	UMBER				
2. [								4.													
24. /	A. DATE From	E(S) OF S	ERVICE To	)	B. PLACE OF	C.	D. PROC		ES, SER\			LIES	E. DIAGNOSIS	F.		G. DAYS OR	H. EPSDT Family	I. ID.		REND	J. ERING
MM	DD	YY M	IM DD	YY	SERVICE	EMG	CPT/HC	CPCS		MOE	DIFIER		POINTER	\$ CHARG	SES	UNITS	Plan	QUAL.		PROVID	ER ID. #
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																		NPI			
				1	1						1	1						 NPI			
25. F	EDERAL TA	AX I.D. NU	JMBER	SS	N EIN	26. 1	L PATIENT'S	S ACCO	UNT NO.	. 2	27. ACCE	PT ASS rt. claims,	IGNMENT? see back)	28. TOTAL C	HARGE	29	. AMOUI		D	30. BAL	ANCE DUE
21 0	SIGNATURE	OF BUN	SICIANIO	D SI IDDI	JEP.	20.1	SEDVICE	EAC!! IT	V I OC *		YES		NO	\$	DDOVIDE:	\$		/		\$	
(	SIGNATURE NCLUDING I certify that apply to this b	DEGREE the staten	S OR CR nents on	REDENTIA the revers	ALS se	32. 8	SERVICE	FACILIT	Y LOCA	TION INF	-UKMA (1	ON		33. BILLING I	-KOVIDEF	1 INFO &	. PH #	(	)		
					_	a.	N.	IDI	b	).				a.	IDI	b.				_	
SIGN	1ED			DAT	Έ	1	1		ľ							[					