

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

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
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)
8. PATIENT STATUS
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

PATIENT AND INSURED INFORMATION

14. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER
24. A DATE(S) OF SERVICE B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES E DIAGNOSIS CODE
F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE

PHYSICIAN OR SUPPLIER INFORMATION

Table with 11 columns (A-K) and 6 rows for service details.

25. FEDERAL TAX I.D. NUMBER
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
31. NATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #