



SCREENING

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)			MEDICAID <input type="checkbox"/> (Medicaid#)			TRICARE <input type="checkbox"/> (ID#/DoD#)			CHAMPVA <input type="checkbox"/> (Member ID#)			GROUP HEALTH PLAN <input type="checkbox"/> (ID#)			FECA BLK LUNG <input type="checkbox"/> (ID#)			OTHER <input type="checkbox"/> (ID#)			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 MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																							
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																							
CITY						STATE						CITY						STATE																							
ZIP CODE						TELEPHONE (Include Area Code) ()						ZIP CODE						TELEPHONE (Include Area Code) ()																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE ADVANTAGE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																							
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 _____																													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____												15. OTHER DATE QUAL. _____ MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																							
17b. NPI _____												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CT01234567												22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. Z00.6 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												23. PRIOR AUTHORIZATION NUMBER _____																													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSCOT Family Plan			I. ID, QUAL.			J. RENDERING PROVIDER ID. #														
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6																								NPI																	
25. FEDERAL TAX I.D. NUMBER						SSN EIN <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$						29. AMOUNT PAID \$						30. Rsvd for NUCC Use					
31. 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 _____												32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____												33. BILLING PROVIDER INFO & PH # () Dr. A a. NPI b. _____																	



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UB-04 CMS-1450 APPROVED OMB NO. 0938-0997  National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



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C1D3 - ARM B

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b				c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION HR	
				14 TYPE		15 SRC	
				16 DHR		17 STAT	
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				28		29 ACCT STATE	
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C2D3 - ARM B

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b				c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
a		b		c		d	
b							
38				39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT	
				a		b	
				b		c	
				c		d	
				d			
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1		CHEST X-RAY		71020		020217	
2		VENIPUNCTURE		36415		020217	
3		CBC		85025		020217	
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23		PAGE ____ OF ____		CREATION DATE		TOTALS	
A		50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	
B		MEDICARE ADVANTAGE				53 ASG. BEN.	
C						54 PRIOR PAYMENTS	
						55 EST. AMOUNT DUE	
						56 NPI	
						57 OTHER	
						58 INSURED'S NAME	
						59 P. REL.	
						60 INSURED'S UNIQUE ID	
						61 GROUP NAME	
						62 INSURANCE GROUP NO.	
						63 TREATMENT AUTHORIZATION CODES	
						64 DOCUMENT CONTROL NUMBER	
						65 EMPLOYER NAME	
						66 DX	
						67	
						68	
						69 ADMIT DX	
						70 PATIENT REASON DX	
						71 PPS CODE	
						72 ECI	
						73	
						74 PRINCIPAL PROCEDURE CODE	
						75	
						76 ATTENDING NPI	
						77 OPERATING NPI	
						78 OTHER NPI	
						79 OTHER NPI	
						80 REMARKS	
						81CC a	
						b	
						c	
						d	



FINAL VISIT

HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA																																																	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										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 MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE																																		
ZIP CODE					TELEPHONE (Include Area Code) ()					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																																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. OTHER CLAIM ID (Designated by NUCC)																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																																							
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.										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 _____ DATE _____										SIGNED _____																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17b. NPI _____										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																	
A. _____ B. <u>Z00.6</u> C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____																																																	
E. _____ F. _____ G. _____ H. _____																																																											
I. _____ J. _____ K. _____ L. _____																																																											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID, QUAL. J. RENDERING PROVIDER ID. #																																																											
1 08 01 17 08 01 17 71260 Q1 2																																																											
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6																																																											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Rsvd for NUCC Use									
31. 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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI b.										a. NPI b.																																							

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997  NUBC™ National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF