



SCREENING #2

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
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					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
ZIP CODE					TELEPHONE (Include Area Code) ()					10. IS PATIENT'S CONDITION RELATED TO:									
11. INSURED'S POLICY GROUP OR FECA 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"/>									
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <h3 style="text-align: center; color: blue;">MEDICARE ADVANTAGE</h3>									
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 _____					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>									
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 _____					READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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									
17b. NPI _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
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) ICD Ind. _____					A. Z00.6					23. PRIOR AUTHORIZATION NUMBER _____									
B. _____					C. _____					D. _____									
E. _____					F. _____					G. _____									
I. _____					J. _____					H. _____									
K. _____					L. _____					I. ID. QUAL. _____									
J. RENDERING PROVIDER ID. # _____																			
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					E. DIAGNOSIS POINTER					F. \$ CHARGES									
G. DAYS OR UNITS					H. EPSOT Family Plan					I. ID. QUAL.									
J. RENDERING PROVIDER ID. #																			
1 12 24 16 12 24 16					71260 Q1					1									
2 12 24 16 12 24 16					78300 Q1					1									
3																			
4																			
5																			
6																			
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.)					32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED _____ DATE _____					a. NPI _____					b. _____									
33. BILLING PROVIDER INFO & PH # ()					Dr. B					a. NPI _____ b. _____									

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓