Section B

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS CHAMP ☐ (Sponsor's SSN) VA GROUP HEALTH PLAN ☐ (VA File #) (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER

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

3. PATIENT'S DATE OF BIRTH MM DD YY / /

SEX M ☐ F ☐

4. INSURED'S NAME (First Name, Middle Initial, Last Name)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ (SPECIFY)

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP TELEPHONE NUMBER ( )

ZIP TELEPHONE NUMBER ( )

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

A. OTHER INSURED'S POLICY OR GROUP NUMBER

A. PATIENT'S EMPLOYMENT? YES ☐ NO ☐

A. PATIENT'S DATE OF BIRTH MM DD YY / / SEX M ☐ F ☐

B. OTHER INSURED'S DATE OF BIRTH MM DD YY / / SEX M ☐ F ☐

B. AN AUTO ACCIDENT? YES ☐ NO ☐

B. EMPLOYER'S NAME OR SCHOOL NAME

C. OTHER ACCIDENT? YES ☐ NO ☐

C. EMPLOYER'S NAME OR SCHOOL NAME

C. INSURANCE PLAN NAME OR PROGRAM NAME

D. INSURANCE PLAN NAME OR PROGRAM NAME

D. RESERVED FOR LOCAL USE

D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return & complete item 9 A-D

12. PATIENT'S OR AUTHORIZED PERSONS' 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.

Signature: _____ Date: _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to undersigned physician or supplier for services described below.

Signature: _____ Date: _____

14. DATE OF CURRENT MM DD YY / / ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY / /

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM: / / MM DD YY TO: / /

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: / / MM DD YY TO: / /

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____.____ 2. _____.____

3. _____.____ 4. _____.____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICES FROM MM/DD/YY	TO MM/DD/YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H DPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
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25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES ☐ NO ☐

28. TOTAL CHARGES $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements apply to this bill and are made a part thereof)

Signed: _____ Date:_____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).

33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE#

PIN # GRP#

PLACE OF SERVICE CODES

1-(H) - INPATIENT HOSPITAL
2-(OH)-OUTPATIENT HOSPITAL
3-(O)-DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5-DAYCARE FACILITY (PSY)
6-NIGHT CARE FACILITY(PSY)
7-(NH) NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9-AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B-OTHER