

Dating your claim forms

Box 14 should always be filled out. It is based on the patient's current services. We use this date to determine if the service is an emergency.

Box 15 is only used if the policy indicates there is a pre-existing waiting period. You can verify this by calling 1-800-972-8088 and selecting "eligibility." If the quote indicates there is a pre-existing waiting period, you must fill in this box. We use this date to determine pre-existing conditions. Use the date the patient was seen for the first time, for this condition, even if seen by another physician other than you. This date should be obtained from the patient, during the history and physical.

EXAMPLE:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--------|-----------------------------------|---|--|--|--|---|--|---------------|--|------------------|--|----------------------|--|-------------|--|--|--|--|--|--|--------------------|--|--|--|--|---|--|--|--|--|
| PICA | | | | | | | | | | PICA | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> (SSN) 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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | | | | | CITY | | | | | STATE | | | | | | | | | | | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | | | | | 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. OTHER INSURED'S DATE OF BIRTH MM DD YY | | | | | | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | 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. RESERVED FOR LOCAL USE | | | | | | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i> | | | | | | | | | | | | | | |
| 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 _____ as my agent for _____ | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED _____ DATE _____ | | | | | | | | | | SIGNED _____ DATE _____ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY | | | | | | | | | | 16. DATE OF PREVIOUS ILLNESS FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 17a. _____ | | | | | 17b. NPI _____ | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | | | | | 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) OPT/HCPCS MODIFIER | | | | E. DIAGNOSIS POINTER | | F. \$ CHARGES | | G. DAYS OF UNITS | | H. EP30T Family Plan | | I. ID. QUAL | | J. RENDERING PROVIDER ID. # | | | | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | SSN EIN | | | | | 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. BALANCE DUE \$ | | | | |
| 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. _____ | | | | | | | | | |

Always use Box 14.

Only use Box 15 if the policy indicates there is a pre-existing waiting period.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION