

**HEALTH INSURANCE CLAIM FORM**

CARRIER

þÿ

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA

*(Medicare#) (Medicaid#) (ID#/DuD#) (Member lD#)*

HEALTH PLAN Bt UNG BI DER 1a. INSURED'S I.D. NUMBER

D

PICA

(For Program in Item 1)

F

CITY

ZIP CODE

# ( )

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

STATE

Self Childs Other

1. FOR NUCC USE

YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT?

YES NO

**CITY**

ZIP CODE

# ( )

1. DATE OF BIRTH MM DD YY

STATE

YES NO *If yes,*

PATIENT AND INSURED INFORMATION

SIGNED

15. OTHER QUAL.)

17a.

17b. NPI

* 1. B.

E. F.

J. K.

DATE

ICD Ind.

D. H.

L.

SIGNED

MM DD YY

FROM

MM DD YY

FROM

1. OUTSIDE LAB:\*

NO

MM DD YY

TO

MM DD YY

TO

$ CHARGES

ORIGINAL REF. NO.

* 1. A. DATE(S) OF SERVICE From To

MM DD YY MM DD YY

### 1

2

3

4

5

6

B. PLACE OF gERV|CE

C. D. EMG

E. DIAGNOSIS POINTER

$ CHARGES

G. H.

I.

NPI

NPI

NPI

NPI

NPI

RENDERING PROVIDER ID. #

* 1. FEDERAL TAX I.D. NUMBER

EIN

* 1. PATIENT’S ACCOUNT NO.

YES NO

1. TOTAL CHARGE
2. AMOUNT PAID

## ( )

1. Rsvd for NUCC Use

SIGNED

DATE a.

1. a.

**PLEASE PRINT OR TYPE**

b.

#### APPROVED OMB-0938-1197 FORM 1500 (02-12)

