1500 **HEALTH INSURANCE CLAIM FORM**

EALTH INSURANCE						
						PICA
MEDICARE MEDICAID	TRICARE CHAMP		OTHER 1a. INSU	RED'S I.D. NUMBER		(For Program in Item 1)
(Medicare #) (Medicaid #)	(Sponsor's SSN) (Member	$(D#) \square (SSN \text{ or } ID) \square (SSN) \square (SSN)$	(ID)			
PATIENT'S NAME (Last Name, First Na	ame, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSUR	ED'S NAME (Last Nam	e, First Name, Mi	ddle Initial)
		MF				
PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	7. INSUR	ED'S ADDRESS (No., S	Street)	
	07.77	Self Spouse Child Other				07475
TY	STATE		CITY			STATE
P CODE TELEP	PHONE (Include Area Code)	Single Married Other		=	TELEPHONE (Include Area Code)
(Employed Full-Time Part-Time Student Student)
OTHER INSURED'S NAME (Last Name	, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TC	. 11. INSUI	RED'S POLICY GROUP	P OR FECA NUM	BER
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OTHER INSURED'S POLICY OR GROU	UP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSUR	ED'S DATE OF BIRTH		SEX
		YES NO			м	F
OTHER INSURED'S DATE OF BIRTH	SEX	b. AUTO ACCIDENT? PLACE (State) b. EMPLO	YER'S NAME OR SCH	HOOL NAME	
	M F					
EMPLOYER'S NAME OR SCHOOL NA	ME	c. OTHER ACCIDENT?	c. INSUR	ANCE PLAN NAME OF	PROGRAM NAM	ЛЕ
. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
				YES NO If yes, return to and complete item 9 a-d.		
PATIENT'S OR AUTHORIZED PERSO	ON'S SIGNATURE I authorize the	e release of any medical or other information neces er to myself or to the party who accepts assignment	sary payme			d physician or supplier for
below.	ment of government benefits ellife	a to mysell of to the party who decepts assignment	Servic	es described below.		
		DATE				
SIGNED		DATE	SIG	NED		
DATE OF CURRENT:	(First symptom) OR 15				O WORK IN CUF	
DATE OF CURRENT: MM DD YY PREGNA	NCY(LMP)	. IF PATIENT HAS HAD SAME OR SIMILAR ILL GIVE FIRST DATE MM DD YY	NESS. 16. DATE FROM	S PATIENT UNABLE T MM DD Y 1 I I	ТО	
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