

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 BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)	1a. <b>INSURED'S I.D. NUMBER</b> (For Program in Item 1)	
2. <b>PATIENT'S NAME</b> (Last Name, First Name, Middle Initial)	3. <b>PATIENT'S BIRTH DATE</b> MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. <b>PATIENT'S ADDRESS</b> (No., Street)	6. <b>PATIENT RELATIONSHIP TO INSURED</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )	8. <b>PATIENT STATUS</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	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 SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	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? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.
12. <b>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</b> 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 _____	13. <b>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____	SIGNED _____	
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 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? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ 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	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) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER	F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1		NPI
2		NPI
3		NPI
4		NPI
5		NPI
6		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>
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 Jane Fortune Counseling LLC 4999 Carolina Forest Blvd Ext Myrtle Beach SC 29579	33. BILLING PROVIDER INFO & PH # (843)268-4980 Jane Fortune LPC 700 Elizabeth Ct B-1 Dillon SC 29536
SIGNED _____ DATE _____	a. NPI b.	a. NPI b.

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION