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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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Mail to: WISE Claims P.O. Box 775 Middletown, CT, 06457

CARRIER PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRICARE-CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a. INSURED'S I.D. NUMBER 123456789 2. PATIENT'S NAME Smith, John, Q. 3. PATIENT'S BIRTH DATE 01/01/1961 4. INSURED'S NAME 5. PATIENT'S ADDRESS 123 Main Street 6. PATIENT RELATIONSHIP TO INSURED Self 7. INSURED'S ADDRESS 8. PATIENT STATUS Single 9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Participant Signature or SOF 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS OR INJURY 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER

Table with 6 rows and 11 columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. TYPE OF SERVICE, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS CODE, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSONI Family Plan, I. EMG, J. COB, K. RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER 123456789 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE \$ 470.56 29. AMOUNT PAID \$ 0 30. BALANCE DUE \$ 470.56 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #