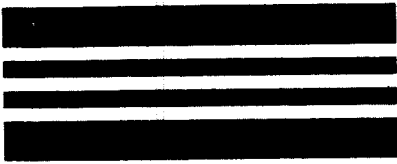


PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		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"/>	
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"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		8. PATIENT STATUS 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"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <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)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
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.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED DATE		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 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.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
SIGNED DATE		FROM MM DD YY TO MM DD YY	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE		FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
1. _____ 3. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE			
MM DD YY MM DD YY			
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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
SIGNED DATE		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
		PIN# GRP#	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION