1SAMPLE- WCB Auth provider

carrier/wcb-carrier-id
payer/name
payer/addr1
payer/addr2
payer/city-state-zip

insured/program

insured/name-address/telephone/area-code

insured/name-address/telephone/phone-number

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

patient/date-of-birth

patient/gender

patient/relationship-to-insured

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
insured/id-number

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
patient/last-name-first-name-middle-initial

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
insured/name-address/last-name-first-name-middle-initial

5. PATIENT'S ADDRESS (No., Street)
patient/name-address/address

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
insured/name-address/address

insured/name-address/state

CITY
patient/name-address/city

STATE

8. RESERVED FOR NUCC USE

patient/name-address/state

CITY
insured/name-address/city

STATE

ZIP CODE
patient/name-address/zip

TELEPHONE (Include Area Code)
( )

patient/name-address/telephone/area-code

patient/name-address/telephone/phone-number

ZIP CODE
insured/name-address/zip

TELEPHONE (Include Area Code)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
insured/other-insured/last-name-first-name-middle-initial

10. IS PATIENT'S CONDITION RELATED TO:

patient/employment-flag
patient/auto-accidentt-flag
patient/auto-accidentt-state
patient/other-accidentt-flag

11. INSURED'S POLICY GROUP OR FECA NUMBER
insured/policy-group-or-feca-number

a. OTHER INSURED'S POLICY OR GROUP NUMBER
insured/other-insured/policy-or-group-number

a. EMPLOYMENT? YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX

not used

insured/other-claim-id/qualifier

b. RESERVED FOR NUCC USE
reserved-field-9b/claimant-first-name reserved-field-9b/claimant-last-name

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)
insured/other-claim-id/identifier

c. RESERVED FOR NUCC USE
not used

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
insured/insurance-plan-name-or-program-name

d. INSURANCE PLAN NAME OR PROGRAM NAME
insured/other-insured/insurance-plan-name-or-program-name

10d. CLAIM CODES (Designated by NUCC)
patient/claim-codes

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

patient/date-of-current-illness-injury-or-pregnancy/date

patient/date-of-current-illness-injury-or-pregnancy/qualifier

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

insured/another-health-benefit-plan-flag

SIGNED patient/signature/signed-name DATE patient/signature/signed-date

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL.

patient/other-date/qualifier patient/other-date/date

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

patient/dates-patient-unable-to-work-in-current-operation/from-date

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

physician-or-supplier/referring-provider-or-other-source/qualifier
physician-or-supplier/referring-provider-or-other-source/name

17a. physician-or-supplier/referring-provider-or-other-source/other-id-number/qualifier

17b. physician-or-supplier/referring-provider-or-other-source/other-id-number/id-number
physician-or-supplier/referring-provider-or-other-source/npi-number

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

physician-or-supplier/hospitalization-dates-related-to-current-services/from-date

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES

physician-or-supplier/outside-lab-flag
physician-or-supplier/outside-lab-flag/charges

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

physician-or-supplier/diagnosis-or-nature-of-illness-or-injury/diagnosis-code

A. B. C. D. E. F. G. H. I. J. K. L.

physician-or-supplier/diagnosis-or-nature-of-illness-or-injury/ICD-indicator

22. RESUBMISSION CODE ORIGINAL REF. NO.

physician-or-supplier/resubmission/code

23. PRIOR AUTHORIZATION NUMBER

physician-or-supplier/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. NPI

physician-or-supplier/procedure-service-or-supply/rendering-provider-id-number/id-number

1

physician-or-supplier/procedure-service-or-supply/from-date
physician-or-supplier/procedure-service-or-supply/to-date

NPI

2

physician-or-supplier/procedure-service-or-supply/place-of-service

physician-or-supplier/procedure-service-or-supply/diagnosis-pointer

3

physician-or-supplier/procedure-service-or-supply/emergency-flag

physician-or-supplier/procedure-service-or-supply/charges

4

additional-claim-information/wcb-authorization-number
additional-claim-information/wcb-rating-code
additional-claim-information/report-type-code
additional-claim-information/transmission-type-code
additional-claim-information/attachment-control-id
additional-claim-information/carrier-recieved-date

physician-or-supplier/procedure-service-or-supply/cpt-hcpcs-code

physician-or-supplier/procedure-service-or-supply/days-or-units

5

physician-or-supplier/procedure-service-or-supply/modifier-a
physician-or-supplier/procedure-service-or-supply/modifier-b
physician-or-supplier/procedure-service-or-supply/modifier-c
physician-or-supplier/procedure-service-or-supply/modifier-d

NPI

6

physician-or-supplier/procedure-service-or-supply/rendering-provider-id-number/qualifier

25. FEDERAL TAX I.D. NUMBER SSN EIN

physician-or-supplier/federal-tax-id-number
physician-or-supplier/federal-tax-id-number/type

26. PATIENT'S ACCOUNT NO.

physician-or-supplier/patients-account-no

27. ACCEPT ASSIGNMENT?

physician-or-supplier/accept-assignment-flag

28. TOTAL CHARGE $

physician-or-supplier/total-charge

29. AMOUNT PAID $

physician-or-supplier/amount-paid

30. Rsvd for NUCC Use

physician-or-supplier/procedure-service-or-supply/rendering-provider-npi-number

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.)

physician-or-supplier/signature

SIGNED physician-or-supplier/signature/signed-date DATE

32. SERVICE FACILITY LOCATION INFORMATION

physician-or-supplier/service-facility/name
physician-or-supplier/service-facility/address
physician-or-supplier/service-facility/city-state-zip

a. NPI b.

physician-or-supplier/service-facility/other-id-number/qualifier
physician-or-supplier/service-facility/other-id-number

physician-or-supplier/service-facility/npi-number

33. BILLING PROVIDER INFO & PH # ( )

physician-or-supplier/billing-provider/name
physician-or-supplier/billing-provider/address
physician-or-supplier/billing-provider/city-state-zip

a. NPI b.

physician-or-supplier/billing-provider/other-id-number/id-number

physician-or-supplier/billing-provider/other-id-number/qualifier

physician-or-supplier/billing-provider/npi-number

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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