



HEALTH INSURANCE CLAIM FORM

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

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. RESERVED FOR NUCC USE; 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; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP); 15. OTHER DATE; 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION; 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE; 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES; 19. ADDITIONAL CLAIM INFORMATION; 20. OUTSIDE LAB? \$ CHARGES; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. RESUBMISSION CODE ORIGINAL REF. NO.; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSTD Family Plan; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. Pswd. for NUCC Use; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

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

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. RESERVED FOR NUCC USE; 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; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP); 15. OTHER DATE; 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION; 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE; 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES; 19. ADDITIONAL CLAIM INFORMATION; 20. OUTSIDE LAB? \$ CHARGES; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. RESUBMISSION CODE ORIGINAL REF. NO.; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSDT Family Plan; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. Pswd. for NUCC Use; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION