PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

5. PATIENT'S SEX — MALE ☐ ☐ FEMALE

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)

7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT — YES ☐ ☐ NO

B. ACCIDENT — AUTO ☐ ☐ OTHER

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11.a. CHAMPUS SPONSOR'S :

STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL 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. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16.a. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY — FROM — THROUGH

DATES OF PARTIAL DISABILITY — FROM — THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES:

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

B.
EPSDT YES ☐ ☐ NO
FAMILY PLANNING YES ☐ ☐ NO

PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE:

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form **HCFA-1500 (C-2) (1-84)** Form **OWCP-1500**
Form **CHAMPUS-501** Form **RRB-1500**