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|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|
| PICA  |  |  |  |  |  |  |  |  |  | PICA   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/><br><small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small> |  |  |  |  |  |  |  |  |  | 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 <input type="text"/> <input type="text"/> <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F   |  |  |  |  |  |  |  |  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)  |  |  |  |  |  |  |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 7. INSURED'S ADDRESS (No., Street)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| CITY  |  |  |  |  |  |  |  |  |  | STATE  |  |  |  |  |  |  |  |  |  | 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | CITY  |  |  |  |  |  |  |  |  |  | STATE                    |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| ZIP CODE  |  |  |  |  |  |  |  |  |  | TELEPHONE (Include Area Code) ( )  |  |  |  |  |  |  |  |  |  | ZIP CODE   |  |  |  |  |  |  |  |  |  | TELEPHONE (Include Area Code) ( )   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)   |  |  |  |  |  |  |  |  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |  |  |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   |  |  |  |  |  |  |  |  |  | a. INSURED'S DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F  |  |  |  |  |  |  |  |  |  | b. EMPLOYER'S NAME OR SCHOOL NAME  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| b. OTHER INSURED'S DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F   |  |  |  |  |  |  |  |  |  | c. EMPLOYER'S NAME OR SCHOOL NAME  |  |  |  |  |  |  |  |  |  | c. INSURANCE PLAN NAME OR PROGRAM NAME   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| c. EMPLOYER'S NAME OR SCHOOL NAME   |  |  |  |  |  |  |  |  |  | d. INSURANCE PLAN NAME OR PROGRAM NAME   |  |  |  |  |  |  |  |  |  | 10d. RESERVED FOR LOCAL USE  |  |  |  |  |  |  |  |  |  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 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.<br>SIGNED _____ DATE _____   |  |  |  |  |  |  |  |  |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNED _____  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY  |  |  |  |  |  |  |  |  |  | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY   |  |  |  |  |  |  |  |  |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY                                     |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  |  |  |  |  |  |  |  |  |  | 17a. _____<br>17b. NPI _____   |  |  |  |  |  |  |  |  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY                                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 19. RESERVED FOR LOCAL USE  |  |  |  |  |  |  |  |  |  | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____   |  |  |  |  |  |  |  |  |  | 22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)<br>1. _____ 3. _____<br>2. _____ 4. _____  |  |  |  |  |  |  |  |  |  | 23. 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. #   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 1   |  |  |  |  |  |  |  |  |  | NPI  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 2   |  |  |  |  |  |  |  |  |  | NPI  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 3   |  |  |  |  |  |  |  |  |  | NPI  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 4   |  |  |  |  |  |  |  |  |  | NPI  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 5   |  |  |  |  |  |  |  |  |  | NPI  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 6   |  |  |  |  |  |  |  |  |  | NPI  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 26. PATIENT'S ACCOUNT NO.  |  |  |  |  |  |  |  |  |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO         |  |  |  |  |  |  |  |  |  | 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.)<br>SIGNED _____ DATE _____   |  |  |  |  |  |  |  |  |  | 32. SERVICE FACILITY LOCATION INFORMATION<br>a. NPI _____ b. _____   |  |  |  |  |  |  |  |  |  | 33. BILLING PROVIDER INFO & PH # ( )<br>a. NPI _____ b. _____  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION