# HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medica NR) 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) R

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) S

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial) R

5. PATIENT'S ADDRESS (No., Street) S

6. PATIENT RELATIONSHIP TO INSURED Self Spouse R Child Other

7. INSURED'S ADDRESS (No., Street) S

CITY STATE

8. RESERVED FOR NUCC USE NR

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) S

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER S

a. OTHER INSURED'S POLICY OR GROUP NUMBER S

a. EMPLOYMENT? (Current or Previous) YES S NO

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

b. RESERVED FOR NUCC USE NR

b. AUTO ACCIDENT? YES S NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC) NR

c. RESERVED FOR NUCC USE NR

c. OTHER ACCIDENT? YES S NO

c. INSURANCE PLAN NAME OR PROGRAM NAME S

d. INSURANCE PLAN NAME OR PROGRAM NAME S

10d. CLAIM CODES (Designated by NUCC) S

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

**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. R

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. R

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

15. OTHER DATE QUAL. S MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD S YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE S

17a. NR

17b. NPI S

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD S YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) S

20. OUTSIDE LAB? YES NO S $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE S ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER S

| 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 R | | R | S | R | S | R | R | R | S | S NPI | S S |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN R

26. PATIENT'S ACCOUNT NO. S

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES S NO

28. TOTAL CHARGE $ R

29. AMOUNT PAID $ S

30. Rsvd for NUCC Use NR

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.) R

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION S

a. S PI b. NR

33. BILLING PROVIDER INFO & PH # ( ) R

a. R PI b. S

**Key: "R" – Required in filing a claim**
**"NR" – Not required, not used**
**"S" – Situational, only used if appropriate specific to claim**

**1. TYPE OF HEALTH INSURANCE COVERAGE** NR

**1A. INSURED'S ID NUMBER** R
Enter the insured's ID number as shown on insured's ID card, including 3 character alpha prefix and 2 character suffix when applicable

**2. PATIENT'S NAME** S
Enter name of person who received the treatment/supplies
REQUIRED when Box 6 is not equal to 'SELF'

**3. PATIENT'S BIRTHDATE/SEX** S
Enter the patient's 8-digit birth date and an 'X' in the correct box to indicate gender of the patient
REQUIRED when Box 6 is not equal to 'SELF'

**4. INSURED'S NAME** R
Enter the insured's full last name, first name, and middle initial. 'Same' is acceptable when Box 2 is complete

**5. PATIENT'S ADDRESS/TELEPHONE NUMBER** S
Enter the patient's permanent address.
REQUIRED when Box 6 is not equal to 'SELF'

**6. PATIENT'S RELATIONSHIP TO INSURED** R
Enter an 'X' in the correct box to indicate the patient's relationship to insured. Only one box can be marked
If the patient is NOT the insured, do NOT select 'SELF'

**7. INSURED'S ADDRESS** S
Enter the insured's permanent address, REQUIRED when Box 6 is equal to 'SELF'

**8. RESERVED FOR NUCC USE** NR

**9. OTHER INSURED'S NAME** S
If Box 11d is marked, complete boxes 9, 9a, and 9d, otherwise leave blank

**9A. OTHER INSURED'S POLICY or GROUP NUMBER** S
Enter the policy or group number of the insured

**9B. RESERVED FOR NUCC USE** NR

**9C. RESERVED FOR NUCC USE** NR

**9D. INSURANCE PLAN NAME OR PROGRAM NAME** S
Enter the other insured's insurance plan or program name

**10A-C IS THE PATIENT'S CONDITION RELATED TO:** S
When appropriate, enter an 'X' in the correct box whether one or more of the services described in Boxes 24 are for a condition or injury that occurred on the job or as a result of an auto or other accident
If Box 10B is marked, a valid State code is REQUIRED
Only one box on each line can be marked

**10D. CLAIM CODES (Designated by NUCC)** S
When applicable, use to report appropriate condition codes
Need approved Condition Codes, see NUCC manual (www.nucc.org) under Code Sets

**11. INSURED'S POLICY, GROUP, or FECA NUMBER** S
Enter the insured's policy/group number

**11A. INSURED'S DATE OF BIRTH/SEX** S
Enter the insured's 8-digit birth date and an 'X' in the correct box to indicate gender of the insured
REQUIRED when Box 6 is equal to 'SELF'

**11B. OTHER CLAIM ID (Designated by NUCC)** NR

**11C. INSURANCE PLAN NAME or PROGRAM NAME** S
Enter insured's insurance plan or program name

**11D. IS THERE ANOTHER HEALTH BENEFIT PLAN?** S
When appropriate, enter an 'X' in the correct box
If marked 'YES', complete Boxes 9, 9a, and 9d

**12. PATIENT'S or AUTHORIZED PERSON'S SIGNATURE** R
Enter 'Signature on File', 'SOF', or legal signature
If no signature on file, leave blank

**13. INSURED'S or AUTHORIZED PERSON'S SIGNATURE** R
Enter 'Signature on File', 'SOF', or legal signature
If no signature on file, leave blank

**14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)** S
Enter date of the first date of the present illness, injury, or pregnancy. If present, a valid qualifier is REQUIRED and should be entered to the right of the vertical, dotted line

**15. OTHER DATE** S
Enter another date related to patient's condition or treatment
If present, a valid qualifier is REQUIRED and should be entered between the left-hand set of vertical, dotted lines
Accident Date (Qualifier 439) is required if 10B or 10C is checked Yes *Need qualifier, see NUCC manual (www.nucc.org)*

**16. DATES PATIENT UNABLE TO WORK IN CURRENT CONDITION** S
If the patient is employed an is unable to work in current condition, a date must be shown

**17. NAME OF REFERRING PHYSICIAN or OTHER SOURCE** S
Enter the name (first name, middle initial, last name) of the referring, ordering, or supervising provider
If present, a valid qualifier is REQUIRED and should be entered to the left of the vertical, dotted line
*Need qualifier, see NUCC manual (www.nucc.org)*

**17A. OTHER ID#** NR

**17B. NPI #** S
Enter the NPI of the referring, ordering, or supervising provider

**18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** S
Enter the inpatient hospital admission date followed by discharge date (if discharge has occurred)
If not discharged, leave discharge date blank
Admission date is REQUIRED when first occurrence in 24B is equal to '21'

**19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)** S
Taxonomy Code of the servicing provider may be entered here. First two characters must be 'ZZ', followed immediately by 10 digit taxonomy code

**20. OUTSIDE LAB? $CHARGES** S
Select 'Yes' or 'No' to indicate if services were provided by an independent provider. If, 'Yes', enter charges

**21. DIAGNOSIS or NATURE OF ILLNESS OR INJURY** R
Enter the applicable ICD indicator to identify the version of the ICD codes being reported between the vertical, dotted lines in the upper right-hand portion of the field
9 = ICD-9-CM
0 = ICD-10-CM
Enter the codes ICD codes, primary first, followed by other diagnoses, if applicable, in the fields A-L

**22. RESUBMISSION and/or ORIGINAL REFERENCE NUMBER** S
List the original reference number for resubmitted claims
When resubmitting a claim, enter the appropriate bill frequency code, left justified in the left-hand side of the field
7 = Replacement of prior claim
8 = Void/cancel of prior claim

**23. PRIOR AUTHORIZATION NUMBER** S
Enter the prior authorization number, referral number, pre-certification number, or Clinical Laboratory Improvement Amendments number (CLIA), if applicable
For Air Ambulance, enter 5 digit zip code of point of pickup

**24. SHADED AREA – SUPPLEMENTAL INFORAMTION** S
Area is used accommodate supplemental information, such as NDC codes. For example: If NDC code is entered, the N4 qualifier is REQUIRED
For additional information regarding qualifiers, *see NUCC manual (www.nucc.org), p.45*

**24A. DATE(S) OF SERVICE [lines 1-6]** R
Enter date(s) of service, both the 'From' and 'To' dates. If there is only one date of service, enter that date under 'From'. Leave 'To' blank or re-enter 'From' date.

**24B. PLACE OF SERVICE (lines 1-6]** R
Enter the appropriate two-digit Place of Service code

**24C. EMG [lines 1-6]** S
If the service was an emergency, enter 'Y' for 'Yes', or leave blank if 'NO'

**24D. PROCEDURES, SERVICES, OR SUPPLIES [lines 1-6]** R
Enter CPT or HCPCS cods(s), and modifiers(s) S, if applicable

**24E. DIAGNOSIS POINTER [lines 1-6]** R
Enter the diagnosis code reference letter (pointer) as shown in Box 21 to relate the date of service and the procedures performed
The reference letter(s), up to four per line, should be individually identified and not as a range (i.e. A-D)

**24F. $CHARGES [lines 1-6]** R
Enter the charge for each listed service

**24G. DAYS OR UNITS [lines 1-6]** R
Enter the number of days or units for each line of service
Anesthesia services MUST be reported as total minutes, up to 3 characters in length

**24H. EPSDT/FAMILY PLAN [lines 1-6]** S
If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code

**24I. ID QUALIFIER (SHADED FIELD)** S
Enter the qualifier into the shaded area of 24I, if the provider number is non-NPI (i.e. Taxonomy Code)
*Need qualifier, see NUCC manual (www.nucc.org)*

**24J. RENDERING PROVIDER ID (SHADED FIELD) [lines 1-6]** S
Enter the non-NPI provider # into the shaded area of 24J

**24J. RENDERING PROVIDER ID (NON-SHADED FIELD) [lines 1-6]** S
REQUIRED if the Rendering Provider NPI is different from the Billing Provider NPI in Box 33A

**25. FEDERAL TAX ID NUMBER** R
Enter the 'Federal Tax ID Number' (employer ID or SSN) of the Billing Provider identified in Box 33
Enter an 'X' in the appropriate box to indicate which number you are reporting

**26. PATIENT'S ACCOUNT NUMBER** S
Enter the account number of the patient, if applicable

**27. ACCEPT ASSIGNMENT?** S
Enter 'X' in the correct box

**28. TOTAL CHARGE** R
Enter total charges for the services (total of charges in 24F)

**29. AMOUNT PAID** S
Enter total amount the other payers paid on the covered services

**30. RESERVED FOR NUCC USE** NR

**31. SIGNATURE OF PHYSICIAN, OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS** R
Enter the legal signature of the practitioner or supplier with a valid date

**32. SERVICE FACILITY LOCATION INFORMATION** S
Enter the location where the services were rendered
REQUIRED if different from Billing Provider Address

**32A. NPI #** S
Enter the 10-digit NPI number of the Service Facility location

**32B. OTHER ID #** NR

**33. BILLING PROVIDER INFO AND PH#** R
If the Provider that renders the service is part of a Provider Group/Facility and Provider Group/Facility is being paid for those services, then Group/Facility information must be populated in this field
REQUIRED to be a physical address (PO Boxes are not allowed)

**33A. NPI #** R
Enter the 10-digit NPI number of the Billing Provider

**33B. OTHER ID #** S
Enter the two-digit qualifier identifying the non-NPI number followed by the ID number (i.e. Taxonomy Code)