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## **HEALTH INSURANCE CLAIM FORM**

CHAMPUS (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID) (ID) (ID) (SSN) (ID) (ID) (ID) (ID) (ID) (ID) (ID) (ID	ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05			PICA T
MALIEUT S ACCRESS (NI., Smart)  SATIENT REALTHANDER TO NOLLING SET Spouse   CING   OPEN   SATIENT REALTHANDER TO NOLLING SET Spouse   CING   OPEN   STATE   SATIENT SCRICTION   STATE   SATIENT STATUS   SET SPOUSE   CING   OPEN   STATE   SATIENT STATUS   STATE   SATIENT ST	CHAMPUS —	- HEALTH PLAN - BLK LUNG (ID)	1a. INSURED'S I.D. NUMBER (For Pro	ogram in Item 1)
SETATE SOURCE OF CORP.    STATE   SOURCE   CORP.   COTY	PATIENT'S NAME (Last Name, First Name, Middle Initial)	MM   DD   YY	4. INSURED'S NAME (Last Name, First Name, Middle Init	tial)
STATE DEPTONE (Include Area Code) Single   Mented   Other   DEPTONE (Include Area Code) Single   Mented   Other   DEPTONE (Include Area Code) Single   Mented   Other   DEPTONE (Include Area Code) Single   Mented   Deptone   De	PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
THER INSURED'S NAME (Jan Name. First Name. Midds Initial)  10. IS PATIENTS CONTINUE TO TO.  11. INSURED'S ROUCY GROUP NUMBER  2. EMPLOYMENT? (Current or Previous)  3. EMPLOYMENT? (Current or Previous)  3. EMPLOYMENT? (Current or Previous)  3. INSURED'S DATE OF BIRTH  5. SEX  3. AUTO ACCIDENT?  4. INSURED'S DATE OF BIRTH  5. SEX  3. AUTO ACCIDENT?  5. C. OTHER ACCIDENT?  5. C. OTHER ACCIDENT?  5. C. OTHER ACCIDENT?  5. C. OTHER ACCIDENT?  5. SERVED YES  5. NO  5. SERVED YES  5. NO  6. INSURANCE PLAN NAME OR PROGRAM NAME  6. OTHER ACCIDENTS  6. INSURANCE PLAN NAME OR PROGRAM NAME  7. INSURED'S DATE OF BIRTH  5. SEX  5. AUTO ACCIDENT  6. INSURANCE PLAN NAME OR PROGRAM NAME  7. INSURED'S DATE OF BIRTH  5. INSURED'S DATE OF B	Y STATE		CITY	STATE
THER INSURED'S NAME (Last Name. First Name, Middle Inhall)  10. SPATIENT'S CONDITION RELITED TO:  11. INSURED'S POLICY GROUP ON FECA NUMBER  2. EMPLOYMENT'S (CURRING OF PRIVIDAD)  3. EMPLOYMENT'S (CURRING OF PRIVIDAD)  3. INSURED'S DATE OF BIRTH  4. INSURED'S DATE OF BIRTH  5. INSU	CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (Include a	Area Code)
THER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT (Current of Previous)  THER INSURED'S DATE OF BIRTH  SEX  b. ALTO ACCIDENT?  FLACE (State)  FLACE (Stat	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student Student	11. INSURED'S POLICY GROUP OR FECA NUMBER	
THER INCURED'S DATE OF BITTH    VES			an integritable prints of prints	SEX
MM DO Y SALE OF SCHOOL NAME  C. OTHER ACCIDENTY PERSON O  READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I submices the related of or modified cross this canal is the require person of personnel interest and complete item 9 a-d.  SIGNED  DATE OF QUIRENT:  ILLNESS First symptomy OP PRESIDANCY (LMP)  RESERVED FOR LOCAL USE  JULIUSES First symptomy OP PRESIDANCY (LMP)  A DATE (S) OF SERVICE  B. C. D. PROCURES OF MAINTY (Fellate items of the related or produced oreproduced or produced or produced or produced or produced or prod	DELICE INQUESTION DATE OF DISTU		į į M	F
NSURANCE PLAN NAME OR PROGRAM NAME  PEAD BACK OF FORM BETORE COMPLETING & SIGNANT THE FORM PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and protection to proceed the claim. I also request payment of government benefits either to myself or to this party who accepts easilyment below.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and protection to proceed this claim. I also request payment of government benefits either to myself or to this party who accepts easilyment below.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and protection to proceed this claim. I also request payment of government benefits either to myself or to this party who accepts easilyment below.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and protection to proceed this claim. I also request payment of and protection the release of myself or to this party who accepts easilyment below.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and protection to proceed this claim. I also request payment of and protection the release of myself or to this party who accepts easilyment below.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and protection to proceed this claim. I also request payment of and protection to proceed this claim. I also request payment of and protection to proceed this claim. I also request payment of and protection to proceed the claim. I also request payment of and protection to proceed the claim. I also request payment of and protection to proceed the claim. I also request payment of and protection to proceed the claim. I also request payment of and payment payment payment of and payment payme	MM DD YY	PLACE (State)		
INSURANCE PLAN NAME OR PROGRAM NAME  READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  PATIENTS OR AUTHORIZED DEPSIONS SIGNATURE I authorize the release of any medical of other information necessary process the claim. Leave required payment of government derefits either to reying the secrepts and government derefits either to revise to the planty who secrepts and government. SIGNING DISTRICT CONTROLL AND DI	EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  PATENT'S OR AUTHORIZED PERSON'S SIGNIATIVE II authorize the release of ny medical or form information necessary to process this claim. I also request payment of medical benefits to the party who accepts assignment between the understanding physician or supplier for services described below.  SIGNIED  DATE OF CURRENT:  ILLNESS (First symptom) OR PRESNANCY (LMP)  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.   170.   NPI   15. IF PATENT HAS HAD SAME OR SIMILAR ILLNESS. 18. DATES PATENT UNABLE TO WORK IN CURRENT COCUPATION FROM DV Y TO MM DV Y SERVICE SOR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)  22. PRIOR AUTHORIZED OR RESUMBISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZED SERVICE SOR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)  PEDERAL TAXLID. NUMBER  A DATE(S) OF SERVICE  B OWN DV Y MM DV Y SERVICE EMB C C. D. PROCEDURES, SERVICES, OR SUPPLIES EMB DIAGNOSIS OR NATURE I Authorized SIGNIATIVE II AUTHO	NSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
SIGNED  DATE OF CURRENT: LILINESS (First symptom) OR PLANEY (Accident) OR PRESIDENCY (LIMP)  NAME OF REFERRING PROVIDER OR OTHER SOURCE  172. 175. NPI  RESERVED FOR LOCAL USE  173. NPI  RESERVED FOR LOCAL USE  174. 175. NPI  RESERVED FOR LOCAL USE  175. 175. NPI  RESERVED FOR LOCAL USE  176. 177. PRICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual circumstances) POINTER  DIAGNOSIS OF SERVICE  RESERVED FOR LOCAL USE  177. RESERVED FOR LOCAL USE  178. NPI  RESERVED FOR LOCAL USE  179. NPI  RESERVED FOR LOCAL USE  200. OUTSIDE LAST  S CHARGES  VEE NO  RESURVED NO  RESURVE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATUI	RE I authorize
ILLINESS (PRI principal OR MINE)  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  179.  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  179.  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  179.  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  179.  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  NAME OF REFERRING PROVIDER OR OTHER SERVICES.  NAME OF REFERRING PROVIDER OF SERVICES.  NAME OF SERVICES.  NAME OF REFERRING PROVIDER OF SERVICES.  NAME OF SERVICE	to process this claim. I also request payment of government benefits eith	release of any medical or other information necessary er to myself or to the party who accepts assignment		an or supplier for
INULTY Accident (DB) PRESENVED FOR LOCAL USE  RESERVED				
RESERVED FOR LOCAL USE    TO   TO   TO   TO   TO   TO   TO   T	MM   DD   YY   INJURY (Accident) OR	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM   DD   YY	FROM I DD I YY MM I	DD   YY
RESERVED FOR LOCAL USE  20. OUTSIDE LAB?  20. OUTSID LAB?  20. OUTSIDE LAB?  20. OUT				SERVICES DD YY
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)  3.		D.   NP1		
A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES DIAGNOSIS POINTER S CHARGES UNIS PROVIDER ID. # NPI  FEDERAL TAX LD. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? For gord, claims, see back) SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Location in Formation)  SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Location in Formation)  32. SERVICE FACILITY LOCATION INFORMATION  33. BILLING PROVIDER INFO & PH. # ( )  34. L. J. RENDERING PROVIDER ID. # IN. I. I. J. RENDERING PROVIDER ID. # IN. II. I. J. RENDERING PROVIDER ID. # IN. II. II. I. J. RENDERING PROVIDER ID. # IN. II. II. II. II. II. II. II. II. II.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2	,3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION	
A. DATE(S) OF SERVICE From To To DD YY MM DD YY SERVICE EMG C-PTHOPOS MODIFIER  B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)  ID ALL DATE(S) OF SERVICE TO DESCRIPTION OF SERVICE EMG CONTROL SERVICES OF SUPPLIES (Explain Unusual Circumstances)  ID ALL DATE(S) OF SERVICE TO DESCRIPTION OF SERVICE EMG CONTROL SERVICES OF SUPPLIES (Explain Unusual Circumstances)  ID ALL DATE(S) OF SERVICE TO DESCRIPTION OF SERVICE EMG CONTROL SERVICES OF SUPPLIES (Explain Unusual Circumstances)  ID ALL DATE(S) OF SERVICE TO DESCRIPTION OF SERVICE EMG CONTROL SERVICES OF SERVICE SERVICES OF SUPPLIES (ID ALL DATE)  ID ALL DATE(S) OF SERVICE TO DESCRIPTION OF SERVICES OF SERV	L 3.	L	- 4	
FEDERAL TAX I.D. NUMBER SSN EIN  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.)  PLACE OF EXPLAIN Unusual Circumstances)  MODIFIER  PLACE OF EXPLAIN Unusual Circumstances)  MODIFIER  POINTER  S CHARGES  DIAGNOSIS S CHARGES  DAYS S PROT I.D. NAPI  NPI  NPI  NPI  NPI  NPI  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.)  B. EXPLAIN Unusual Circumstances  DIAGNOSIS POINTER S CHARGES  DAYS S PROT I.D. NAPI  NPI  NPI  NPI  SUBJECTOR (Explain Unusual Circumstances)  ANDIFIER  POINTER S CHARGES  DAYS S PROT I.D. NAPI  NPI  NPI  NPI  SUBJECTOR (Explain Unusual Circumstances)  NPI  NPI  NPI  SUBJECTOR (Explain Unusual Circumstances)  NPI  NPI  NPI  NPI  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.)			25. PRIOR AUTHORIZATION NOWIDER	
FEDERAL TAX I.D. NUMBER SN EIN  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.)  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT?  For gort. Claims, see back)  \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	From To PLACE OF (Exp	plain Unusual Circumstances) DIAGNOSIS	DAYS EPSDT ID.	RENDERING
PEDERAL TAX I.D. NUMBER SSN EIN  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.)  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT?  (For govt. claims, see back)  YES NO  32. SERVICE FACILITY LOCATION INFORMATION  33. BILLING PROVIDER INFO & PH. #			NPI NPI	
FEDERAL TAX I.D. NUMBER SSN EIN  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.)  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT?  (For govt. claims, see back)  YES NO  30. BALANCE DUE  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$			I NPI	
FEDERAL TAX I.D. NUMBER SSN EIN  SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (1 certify that the statements on the reverse apply to this bill and are made a part thereof.)  22. ACCEPT ASSIGNMENT?  (For gout. claims, see back)  YES NO  33. BILLING PROVIDER INFO & PH. #  ( )  a. b. a. b.				
FEDERAL TAX I.D. NUMBER SSN EIN  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.)  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES NO  \$ 30. BALANCE DUE  \$ \$  31. SERVICE FACILITY LOCATION INFORMATION  32. SERVICE FACILITY LOCATION INFORMATION  33. BILLING PROVIDER INFO & PH. #  ()  a. b.			NPI NPI	
FEDERAL TAX I.D. NUMBER SSN EIN  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.)  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT?  (For govt. claims, see back)  \$  \$  NPI  28. TOTAL CHARGE  29. AMOUNT PAID  \$  \$  \$  \$  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.)  a. b.			NPI NPI	
FEDERAL TAX I.D. NUMBER SSN EIN  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES NO  32. SERVICE FACILITY LOCATION INFORMATION  33. BILLING PROVIDER INFO & PH. #  (1)  34. Comparison of the provider information on the reverse apply to this bill and are made a part thereof.)  35. SERVICE FACILITY LOCATION INFORMATION  36. December 1. Comparison of the provider information on the reverse apply to this bill and are made a part thereof.)			NPI NPI	
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INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  a. b. a. b.	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	(For govt. claims, see back)	1	0. BALANCE DUE
	INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse			
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