HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S ID NUMBER (For Program in item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M☐ F☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self☐ Spouse☐ Child☐ Other☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. PATIENT STATUS Single☐ Married☐ Other☐	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )	Employed☐ Full-Time Student☐ Part-Time Student☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐YES ☐NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M☐ F☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M☐ F☐	b. AUTO ACCIDENT? ☐YES ☐NO PLACE (State) |____|	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐YES ☐NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐YES ☐NO ***If yes,*** return to and complete item 9 a-d.
READ BACK OF FROM 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. 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. SIGNED _____

Name of Insurance Company:

Phone Number of Insurance Company:

Address of Insurance Company:

_____ **For Office Use Only** _____

Diagnosis (DSMIV): 1.
2.

Insurance Coverage Information

Number of Visits per Year: Deductible: Deductible Met: Co-Pay:

Percentage Paid by Insurance: Percentage Paid by Patient:

Address for Claims:

Auth/Referral Needed? Where from? Number of Visits Authorized: