



# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																							
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK (LUNG) <input type="checkbox"/> (ID#)					OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S LD. 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 <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																								
5. PATIENT'S ADDRESS (No., Street)															6. PATIENT RELATIONSHIP TO INSURED 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. RESERVED FOR NUCC USE										CITY					STATE																								
ZIP CODE					TELEPHONE (Include Area Code) ( )					9. RESERVED FOR NUCC USE										ZIP CODE					TELEPHONE (Include Area Code) ( )																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)															10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					a. INSURED'S DATE OF BIRTH MM   DD   YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. OTHER CLAIM ID (Designated by NUCC)																			
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 _____										c. INSURANCE PLAN NAME OR PROGRAM NAME																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM   DD   YY															15. OTHER DATE QUAL. 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. _____ 17b. NPI _____															18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																								
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. EPoS/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"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use																			
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.) SIGNED _____ DATE _____															32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____																								

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION