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ABC Insurance Company
Suite 600
567 Insurance Lane
Big City IL 80605

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) [X] | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X0123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe Jr, John, J

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1987 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John, J

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main Street

CITY: Anytown STATE: IL

ZIP CODE: 60610 TELEPHONE (Include Area Code): (312) 5551212

8. 1500 Health Insurance Claim Form
Demo of Version 02/12
Type, Save and Print your claim.
Helpful built-in messages assist the user.
Create unique templates for common claims.
One-time purchase. Unlimited claims.
Works with both Mac & Windows.
For use with Adobe Reader 9 or greater.
Purchase Here

CITY: Anytown STATE: IL

ZIP CODE: 60610 TELEPHONE (Include Area Code): (312) 5551212

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Mary, A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: X9876543210

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ Insurance Company

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: A1234

a. INSURED'S DATE OF BIRTH MM DD YY: 01 01 1958 SEX M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC): Y4 112233445566

c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC Insurance Company

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *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.

SIGNED: Signature on File DATE: 09/30/12

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: SOF

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 30 2012 QUAL. 431

15. OTHER DATE QUAL. 454 MM DD YY: 09 25 2012

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 09 25 2012 TO 10 28 2012

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Jane A Smith MD

17a. G2 ABC1234567890

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 09 25 2012 TO 09 28 2012

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 112500 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 998.59 B. 780.6 C. V18.0 D. E878.8
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: ABC1234567890

23. PRIOR AUTHORIZATION NUMBER

Line	24. A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1																		G2	Z5678901234
	09	30	12	09	30	12	11	Y	99241	25				ABCD	50 00	1	Y	NPI	9876543210
2																			12345678901
	10	01	11	01	01	11	11	N	A6410	P2				ABSS	45 00	11	N	NPI	0123456789
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12341234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 95 00

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.)
Joe Smith MD
SIGNED DATE 09/30/12

32. SERVICE FACILITY LOCATION INFORMATION
General Hospital
9876 Hospital Street
Anytown IL 60610-9876
a. 567891234 b. G2A1234567890

33. BILLING PROVIDER INFO & PH # (312) 5552222
Physician Practice Inc
1234 Healthcare Street
Anytown IL 60610-1234
a. 9876543210 b. G2Z5678901234

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)