

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

BLUE CROSS BLUE SHIELD

PO BOX 1121

MEDICAL

PA 12357-1121

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) XWY312987982	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MATTSON, ROGER, S		3. PATIENT'S BIRTH DATE MM DD YY 09 30 1945 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1312 WEST EASTERDAY		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE BLUEBERRY ME		7. INSURED'S ADDRESS (No., Street) 1312 WEST EASTERDAY	
ZIP CODE TELEPHONE (Include Area Code) 49855 (906) 3121987		CITY STATE BLUEBERRY ME	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code) 49855 (906) 3121987	
Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER 92992	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY 09 30 1945 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME BEEBAH GREETING CARDS	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME BLUE CROSS BLUE SHIELD	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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 MM DD YY			
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 SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 01 03 20YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. NPI		18. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 562.10 3. 272.4		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		E. DIAGNOSIS POINTER	
B. PLACE OF SERVICE C. EMG		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			
1 01 03 YY 11 99214 12 60.00 1 NPI 2345678901			
2 01 03 YY 11 85027 12 30.00 1 NPI 2345678901			
3 01 03 YY 11 80061 12 45.00 1 NPI 2345678901			
4 01 03 YY 11 45330 1 175.00 1 NPI 2345678901			
5 NPI			
6 NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 494134726 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 310.00 29. AMOUNT PAID \$ 000 30. BALANCE DUE \$ 310.00		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.) SIGNATURE ON FILE SIGNED MM DD YY DATE	
32. SERVICE FACILITY LOCATION INFORMATION SUPERIORLAND CLINIC 714 HENNEPIN AVENUE BLUEBERRY ME 49855 a. 4567890123 b.		33. BILLING PROVIDER INFO & PH # (906) 3364600 SUPERIORLAND CLINIC 714 HENNEPIN AVENUE BLUEBERRY ME 49855 a. 4567890123 b.	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION