

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR NEONATAL GROUND AMBULANCE WITHOUT TAXONOMY CODES NO PRIMARY INSURANCE (TPL) A0225 AND A0425 (WITH A0425 "U1" MODIFIER)

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPUS/CHAMPVA/GROUP HEALTH PLAN/FECA BLK LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSTG Family Plan; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR NEONATAL GROUND AMBULANCE WITH TAXONOMY CODE NO PRIMARY INSURANCE (TPL) A0225 AND A0425 (WITH A0425 "U1" MODIFIER)

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/GROUP HEALTH PLAN/FECA BLK LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR NEONATAL GROUND AMBULANCE WITHOUT TAXONOMY CODE NO PRIMARY INSURANCE (TPL) A0225 AND A0425 (WITH A0425 "U1" MODIFIER)

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/CHAMPUS/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSDT Family Plan; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR NEONATAL GROUND AMBULANCE WITH TAXONOMY CODE AND PRIMARY INSURANCE (TPL) A0225 AND A0425 (WITH A0425 "U1" MODIFIER)

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE/SEX; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSOT Family Plan; I. ID. QUAL.; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR ALS EMERGENCY AMBULANCE WITHOUT TAXONOMY CODES AND NO PRIMARY INSURANCE (TPL) A0427 AND A0425

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR ALS EMERGENCY GROUND AMBULANCE WITH TAXONOMY CODE NO PRIMARY INSURANCE (TPL) A0427 AND A0425

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/FECA BLK LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 24. B. PLACE OF SERVICE; 24. C. EMG; 24. D. PROCEDURES, SERVICES, OR SUPPLIES; 24. E. DIAGNOSIS POINTER; 24. F. \$ CHARGES; 24. G. DAYS OR UNITS; 24. H. ERSDOT Family Plan; 24. I. ID. QUAL.; 24. J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR ALS EMERGENCY GROUND AMBULANCE WITH TAXONOMY CODE AND PRIMARY INSURANCE (TPL) A0427 AND A0425

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR FIXED WING AIR AMBULANCE WITHOUT TAXOMY CODES AND NO PRIMARY INSURANCE (TPL) A0430 AND A0435

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

1500

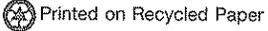
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR FIXED WING AIR AMBULANCE WITH TAXONOMY CODES NO PRIMARY INSURANCE (TPL) A0430 AND A0435

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/FECA BLK LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. ERSOT Family Plan; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR FIXED WING AIR AMBULANCE WITHOUT TAXONOMY CODES WITH PRIMARY INSURANCE (TPL) A0430 AND A0435

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE/SEX; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE FOR FIXED WING AIR AMBULANCE WITH TAXONOMY CODE AND PRIMARY INSURANCE (TPL) A0430 AND A0435

PICA	PICA																						
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input 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) PATIENT 12 DIGIT ID NUMBER																						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT NAME					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)															
5. PATIENT'S ADDRESS (No., Street) PATIENTS ADDRESS					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 CITY			STATE ST		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE												
ZIP CODE ZIP			TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (Include Area Code) ()												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: ANSWER FOLLOWING:			11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME															
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME NAME OF PRIMARY INSURANCE															
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.															
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 DATE 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 SIGNATURE											
14. DATE OF CURRENT: MM DD YY				ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. NPI				17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. DX CODE 3. 4.												22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER											
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. EPOSD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #			
1 TPL150.00 01 01 09 01 01 09 42 Y A0430				Y		A0430				1		1500 00		1				ZZ 3416A0800X NPI NPI NUMBER					
2 TPL100.00 01 01 09 01 01 09 42 Y A0435				Y		A0435				1		1500 00		23				ZZ 3416A0800X NPI NPI NUMBER					
3																		NPI					
4																		NPI					
5																		NPI					
6																		NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO. PATIENT ACCT #				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 3000 00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 3000 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 DATE SIGNED DATE						32. SERVICE FACILITY LOCATION INFORMATION DROP OFF LOCATION ADDRESS CITY, STATE ZIP						33. BILLING PROVIDER INFO & PH # () PHONE PROVIDER NAME ADDRESS CITY, STATE ZIP											
a.						b.						a. NPI NUMBER		b. ZZ3416A0800X									