

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/00

CARRIER

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> PECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Supplement #) (Member ID#) (SSN or ID#) (SN)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000-00-0000					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John			3. PATIENT'S BIRTH DATE MM DD YY 01 02 99 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
7. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			8. PATIENT STATUS Employee <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11. INSURED'S POLICY GROUP OR PECA NUMBER			9. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11. INSURED'S POLICY GROUP OR PECA NUMBER			10. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 5 and 6.			12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
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.						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 _____ DATE _____						SIGNED _____ DATE _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (MFP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____ 17b. (MFI) _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			19. RESERVED FOR LOCAL USE		
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line)						21. MEDICAID RESUBMISSION CODE			22. MEDICAID RESUBMISSION ORIGINAL REF. NO.		
1. 315.2						23. PRIOR AUTHORIZATION NUMBER			24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. ICD-9-CM CODE D. PROCEDURES, SERVICES, OR SUPPLIES (Exclude Unusual Circumstances) E. DIAGNOSIS MONTER F. CHARGES G. DAYS OR UNITS H. EFFECTIVE DATE I. ID. QUAL. J. RENDERING PROVIDER ID.#		
1. 08 15 06 09 30 06 03 T1018 ul uc 1 252 48 1 52 10 1004525						25. FEDERAL TAX ID NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		
25. FEDERAL TAX ID NUMBER SSN EIN						26. PATIENT'S ACCOUNT NO. 10045251000			27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						29. SERVICE FACILITY LOCATION INFORMATION			30. TOTAL CHARGE 252 48 31. AMOUNT PAID 0 00 32. BALANCE DUE		
SIGNED _____ DATE 4/23/09						33. BILLING PROVIDER INFO & PAY# (802) 828-5413 Dept of Education 120 State St. Montpelier, VT 05602			34. BILLING PROVIDER INFO & PAY# (802) 828-5413		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION