

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Example Form - How to Fill Out Form For Insurance Reimbursement

Write the name of Your Insurance Provider Here

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; 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. EPSDT 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 #

First Hand Medical NPI#: 1326273483