



Cyan indicates a Required field that must be completed. Otherwise, claim processing may be delayed or the claim may be returned to the provider.

Green indicates a Conditionally Required field that must be completed when a particular condition is present. Otherwise, claim processing may be delayed or the claim may be returned to the provider.

Yellow indicates an Optional field; information is helpful, but not necessary.

Grey indicates an N/A field that is Not Applicable to HMSA claims processing.

* Asterisk indicates a field for which input error is relatively frequent. Take extra care when completing the field.

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/> <input type="checkbox"/>										PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
(Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code) ()										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER CLAIM ID (Designated by NUCC)																			
c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																			
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 DATE																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____																			
15. OTHER DATE MM DD YY QUAL. _____																			
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. _____																			
17b. NPI _____																			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																			
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____																			
A. _____ B. _____ C. _____ D. _____																			
E. _____ F. _____ G. _____ H. _____																			
I. _____ J. _____ K. _____ L. _____																			
22. 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) (E.) DIAGNOSIS POINTER (F.) \$ CHARGES (G.) DAYS OR UNITS (H.) ICD-9 Family Plan (I.) ID. QUAL. (J.) RENDERING PROVIDER ID. #																			
1 NPI _____																			
2 NPI _____																			
3 NPI _____																			
4 NPI _____																			
5 NPI _____																			
6 NPI _____																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()																			
SIGNED DATE a. NPI b. NPI																			