**HEALTH INSURANCE CLAIM FORM**

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
<td>(Medicare)</td>
</tr>
<tr>
<td>2. PATIENT’S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>3. Patent’s Birth Date</td>
<td>DD MM YY</td>
</tr>
<tr>
<td>4. INSURED’S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>5. PATIENT’S ADDRESS</td>
<td>No., Street</td>
</tr>
<tr>
<td>6. PATIENT RELATIONSHIP TO INSURED</td>
<td>Self, Spouse, Child, Other</td>
</tr>
<tr>
<td>7. INSURED’S ADDRESS</td>
<td>No., Street</td>
</tr>
<tr>
<td>8. RESERVED FOR NUCC USE</td>
<td></td>
</tr>
<tr>
<td>9. OTHER INSURED’S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>10. IS PATIENT’S CONDITION RELATED TO:</td>
<td></td>
</tr>
<tr>
<td>11. IS THIS CLAIM RELATED TO:</td>
<td></td>
</tr>
<tr>
<td>12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>14. DATE OF CURRENT ILLNESS OR CONCEPTION</td>
<td>DD MM YY</td>
</tr>
<tr>
<td>15. HOSPITALIZATION DATES</td>
<td>DD MM YY</td>
</tr>
<tr>
<td>16. OUTSIDE LAB?</td>
<td>YES NO</td>
</tr>
<tr>
<td>17. NAME OF REFERRING PHYSICIAN</td>
<td></td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>DD MM YY</td>
</tr>
<tr>
<td>19. ADDITIONAL CLAIM INFORMATION</td>
<td></td>
</tr>
<tr>
<td>20. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>21. MEDICARE</td>
<td>(Medicare)</td>
</tr>
<tr>
<td>22. DIALED PHONE NUMBER</td>
<td></td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td></td>
</tr>
<tr>
<td>24. DATE(S) OF SERVICE</td>
<td>DD MM YY</td>
</tr>
<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td></td>
</tr>
<tr>
<td>26. PATIENT’S ACCOUNT NO.</td>
<td></td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT?</td>
<td>YES NO</td>
</tr>
<tr>
<td>28. TOTAL CHARGE</td>
<td></td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td></td>
</tr>
<tr>
<td>30. Resvd for NUCC Use</td>
<td></td>
</tr>
</tbody>
</table>

**NUCC Instruction Manual available at:** www.nucc.org

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0938-1197 FORM 1500 (02-12)**
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

M EDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided is true, accurate and complete. In the case of a Medicare/Beneficiary who is through age 12 years old, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the patient has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible for the payment for services for which the Medicare claim is made. See 42 CFR 411.24(a). If item is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare or TRICARE participation cases, the determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program, but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured," i.e., items 1a, 4, 6, 7, 9, and 11. BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral Law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.

For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, and 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I, or any employee who rendered services, are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, other civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black-Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing laws and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF M EDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9357.

The information we obtain to complete claims about these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republihed.


FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPSVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers or carriers relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 101-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0906-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to this form, please write to: CMS, Office of Information Management, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop CA-25-06, Baltimore, Maryland 21244-1850. This address is for comments and/or questions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 2012

| PICA | CAR \n|------|-----|
|      |     |

1. **MEDICARE**
   - [ ] Medicare
   - [ ] Medicaid
   - [ ] Tricare

2. **PATIENT'S NAME**
   - [ ] Last Name, First Name, Middle Initial

3. **PATIENT'S BIRTH DATE**
   - [ ] MM
   - [ ] DD
   - [ ] YYYY

4. **SEX**
   - [ ] M
   - [ ] F

5. **PATIENT'S ADDRESS**
   - [ ] No.
   - [ ] Street

6. **PATIENT RELATIONSHIP TO INSURED**
   - [ ] Self
   - [ ] Spouse
   - [ ] Child
   - [ ] Other

7. **INSURED'S ADDRESS**
   - [ ] No.
   - [ ] Street

8. **ZIP CODE**
   - [ ] TELEPHONE (Include Area Code)

9. **OTHER INSURED'S NAME**
   - [ ] Last Name, First Name, Middle Initial

10. **IS PATIENT'S CONDITION RELATED TO**
    - [ ] Injury
    - [ ] Illness
    - [ ] Other

11. **POLICY GROUP OR FECA NO.**

12. **INSURANCE POLICY OR GROUP NUMBER**

13. **INSURANCE PLAN NAME OR PROGRAM NAME**

14. **DATE OF CURRENT ILLNESS & PREGNANCY**
    - [ ] MM
    - [ ] DD
    - [ ] YYYY

15. **DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**
    - [ ] MM
    - [ ] DD
    - [ ] YYYY

16. **NAME OF REFERRING PROVIDER**

17. **NAME OF PROVIDER**

18. **HOSPITALIZATIONS DATES RELATED TO CURRENT SERVICES**
    - [ ] From
    - [ ] To

19. **INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**

20. **OUTSIDE LAB?**
    - [ ] YES
    - [ ] NO

21. **REIMBURSEMENT CODE**

22. **SERVICE FACILITY LOCATION INFORMATION**

23. **BILLING PROVIDER INFO & PHY.**

24. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - [ ] INCL. DEGREES OR CREDENTIALS
    - [ ] SERVICE FACILITY LOCATION INFORMATION

25. **FEDERAL TAX ID NUMBER**

26. **PATIENT'S ACCOUNT NO.**

27. **ACCEPT ASSIGNMENT?**
    - [ ] YES
    - [ ] NO

28. **TOTAL CHARGE**

29. **AMOUNT PAID**

30. **SEND FOR NUCC USE**

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - [ ] INCL. DEGREES OR CREDENTIALS
    - [ ] SERVICE FACILITY LOCATION INFORMATION

32. **BILLING PROVIDER INFO & PH.**

33. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - [ ] INCL. DEGREES OR CREDENTIALS
    - [ ] SERVICE FACILITY LOCATION INFORMATION

34. **BILLING PROVIDER INFO & PH.**

35. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - [ ] INCL. DEGREES OR CREDENTIALS
    - [ ] SERVICE FACILITY LOCATION INFORMATION

36. **REIMBURSEMENT CODE**

37. **SERVICE FACILITY LOCATION INFORMATION**

38. **BILLING PROVIDER INFO & PH.**

39. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - [ ] INCL. DEGREES OR CREDENTIALS
    - [ ] SERVICE FACILITY LOCATION INFORMATION

40. **REIMBURSEMENT CODE**

41. **SERVICE FACILITY LOCATION INFORMATION**

42. **BILLING PROVIDER INFO & PH.**

43. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - [ ] INCL. DEGREES OR CREDENTIALS
    - [ ] SERVICE FACILITY LOCATION INFORMATION

44. **REIMBURSEMENT CODE**

45. **SERVICE FACILITY LOCATION INFORMATION**

46. **BILLING PROVIDER INFO & PH.**

**NUCC Instruction Manual available at: www.nucc.org**

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0988-1197 FORM 1500 (02-12)**
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA GROUP FECA OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE SEX MM    DD    YY
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. INSURED'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
   Self Child Other
7. INSURED'S DATE OF BIRTH SEX
   MM    DD    YY
8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
    b. AUTO ACCIDENT? PLACE (State)
    c. OTHER ACCIDENT?
    d. INSURANCE PLAN NAME OR PROGRAM NAME
11. 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
12. PATIENT'S ACCOUNT NO. (For govt. claims, see back)
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
14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP)
   MM    DD    YY
15. OTHER DATE
   MM    DD    YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
   FROM TO
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   FROM TO
18. OUTSIDE LAB? $ CHARGES
   YES  NO
19. OUTSIDE SERVICES
   YES  NO
20. OUTSIDE LAB? $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
22. RESUBMISSION CODE  ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. TOTAL CHARGE
25. AMOUNT PAID
26. Rsvd for NUCC Use
27. BILLING PROVIDER INFO & PH #
   ( )
   SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)