PLEASE
DO NOT
STAPLE
IN THIS
AREA

[redacted]

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ADMINISTRATORS

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (VA File #) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): FLM999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LAST, FIRST

3. PATIENT'S BIRTH DATE MM DD YY: 01 | 01 | 2000 — SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): LAST, FIRST

5. PATIENT'S ADDRESS (No., Street): 99999, STREET

6. PATIENT'S RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 99999 , STREET

CITY: CITY — STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒

Employed ☒ Full-Time Student ☐ Part-Time Student ☐

CITY: CITY — STATE: WI

ZIP CODE: 99999 — TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE: 99999 — TELEPHONE (INCLUDE AREA CODE): (999) 999-9999

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: FLM999999

a. INSURED'S DATE OF BIRTH MM DD YY: 01 | 01 | 2000 — SEX: M ☒ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ 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 ______ 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 ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY: 01 | 01 | 2000 — 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)

1. 999 . 01
2. 998 . 01
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. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1.	01 01 00	01 01 00			99999		1,2	100 00					
2.	01 01 00	01 01 00			99998		2	50 00					
3.													
4.													
5.													
6.													

25. FEDERAL TAX I.D. NUMBER: 99-9999999 — SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE $ 150 00

29. AMOUNT PAID $ 150 00

30. BALANCE DUE $ 0 0

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED ______ DATE ______

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): DOCTOR OR FACILITY ADDRESS

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: MEMBER ADDRESS

PIN # — GRP #

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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