PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example Form

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 493L547Z29 Blue Cross

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jane Doe

3. PATIENT'S BIRTH DATE (MM DD YY): 03 17 1963 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): John Doe

5. PATIENT'S ADDRESS (No., Street): 33 Maple Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 33 Maple Lane

CITY: Belmont | STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Belmont | STATE: MA

ZIP CODE: 02478 | TELEPHONE (Include Area Code): (617) 954-6814

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 02478 | TELEPHONE (INCLUDE AREA CODE): (617) 954-6814

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): None

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Blue Cross G549F22

a. OTHER INSURED'S POLICY OR GROUP NUMBER: None

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): 1 19 61 | SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Acme Supplies

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Preferred

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: Jane Doe DATE: 4-6-2009

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: John Doe

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 3 6 09 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 3 6 09

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr William Scott

17a. I.D. NUMBER OF REFERRING PHYSICIAN: C95436

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

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. 354.0 Carpal Tunnel Syndrome
2.
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 3 17 09				L3908	Right Hand	354.0	129 95					
2 3 17 09				L3908	Left Hand	354.0	129 95					
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043813636 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]

28. TOTAL CHARGE: $ 259 90

29. AMOUNT PAID: $ 259 90

30. BALANCE DUE: $ 000

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.)

SIGNED DATE

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

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

800-798-5210
First Hand Medical
3434 East 7800 South Suit328
Salt Lake City, Utah 84121

PIN# 1326273483 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

NPI#

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Phone: 1-800-798-5210