

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

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 ID NUMBER FOR PROGRAM IN ITEM 1							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)				4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No. Street)						6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)				7. INSURED'S ADDRESS (No. Street)											
CITY			STATE			8. PATIENT STATUS (Single, Married, Other)				CITY			STATE								
ZIP CODE			TELEPHONE (Include Area Code)			9. EMPLOYED? (Current or Previous) (YES NO)				ZIP CODE			TELEPHONE (INCLUDE AREA CODE)								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: (a) EMPLOYMENT? (b) AUTO ACCIDENT? (c) OTHER ACCIDENT? (10d) RESERVED FOR LOCAL USE				11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. AUTO ACCIDENT? (YES NO) PLACE (State)				a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)			b. EMPLOYER'S NAME OR SCHOOL NAME								
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)						c. OTHER ACCIDENT? (YES NO)				c. INSURANCE PLAN NAME OR PROGRAM NAME											
c. EMPLOYER'S NAME OR SCHOOL NAME						10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) If yes, return to and complete item 9 a-d.											
d. INSURANCE PLAN NAME OR PROGRAM NAME						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.)				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						DATE				SIGNED											
14. DATE OF CURRENT ILLNESS (First Symptom OR NJUHY Accident OR PRIOR GNANCY/CMPI)				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									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. ID NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)				19. RESERVED FOR LOCAL USE									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)						20. OUTSIDE LAB? (YES NO) \$ CHARGES				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)						23. PRIOR AUTHORIZATION NUMBER				24. TABLE											
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 (EPSDT OR Family Plan)		H EMG		I COB		K RESERVED FOR LOCAL USE	
25. FEDERAL TAX ID NUMBER		SSN/EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (YES NO)				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$					
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. 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 #											
SIGNED						DATE				PIN#		GRP#									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION