

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. 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 <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)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>														
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. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> 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 _____ DATE _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE. MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
B. PLACE OF SERVICE										23. PRIOR AUTHORIZATION NUMBER																			
C. EMG										24. F. \$ CHARGES																			
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER										G. DAYS OR UNITS																			
E. DIAGNOSIS POINTER										H. REPORT Family Pat.																			
										I. ID. QUAL.																			
										J. RENDERING PROVIDER ID. #																			
24										NPI 1972530319																			
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25. FEDERAL TAX I.D. NUMBER 03-0467829										26. PATIENT'S ACCOUNT NO.																			
SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
29. AMOUNT PAID \$										30. BALANCE DUE \$																			
28. TOTAL CHARGE \$										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.) ANTHONY F. KIRKPATRICK, M.D., Ph.D.																			
32. SERVICE FACILITY LOCATION INFORMATION 1910 E. Busch Blvd. Tampa, Florida 33612										33. BILLING PROVIDER INFO & PH # (813) 995-5511 THE RSD/CRPS TREATMENT CENTER & RESEARCH INSTITUTE 1910 E. Busch Blvd. Tampa, Florida 33612																			
SIGNED _____ DATE _____										a. 1972530319 b. 1972530319																			

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION