



HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																																																			
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										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"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																									
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"/>										7. INSURED'S ADDRESS (No., Street)																																																																																									
CITY					STATE					8. RESERVED FOR NUCC USE					CITY					STATE																																																																																									
ZIP CODE					TELEPHONE (Include Area Code) () ()					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																				
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																											
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																																																																															
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 _____ 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 _____																																																																																																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																																															
A. _____ B. _____ C. _____ D. _____										E. _____ F. _____ G. _____ H. _____										I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER																																																																															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPRS/DT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #																			
1										2										3										4										5										6										NPI										NPI										NPI										NPI										NPI									
25. FEDERAL TAX I.D. NUMBER 330165384										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Rsvd for NUCC Use																																																	
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. SERVICE FACILITY LOCATION INFORMATION M. Joan McCloskey, LMFT 25255 Cabot Road, Suite 228 Laguna Hills, CA 92653										33. BILLING PROVIDER INFO & PH # (949) 837-6970																																																																																									
SIGNED _____ DATE _____										a. 1386317287										b. MFC22594										a. 1386317287										b. MFC22594																																																																					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION