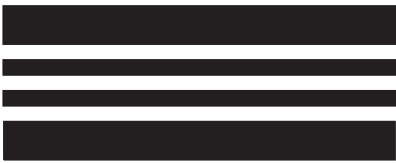


PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #1) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN or ID) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (Street No.) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (Street No.) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Spouse <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: 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	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR NUMBER a. 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. INSURANCE PLAN NAME OR PROGRAM NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	

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 (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		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. 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		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER			

1	A		B	C	D		E	F	G	H	I	J	K
	DATE(S) OF SERVICE From MM DD YY To MM DD YY	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE	\$ CHARGES							
2													
3													
4													
5													
6													

25. FEDERAL TAX ID NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> 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.) SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

ATTENTION PROVIDER — FOR FASTER CLAIM PROCESSING REMEMBER:

- The Insured's certificate number (Item #1a) is critical to the timely and accurate processing of this claim. Remember to include any Alphabetic characters which may precede the certificate number.
- The patient's birth date must be listed. (Item #3)
- The insured's full address and zip code are required. (Item #7)
- Onset date must be completed. (Item #14)
- Diagnosis codes (Items #21 and 24E) and procedure codes (Item #24D) are required.
- The Provider/Supplier SSN or Tax ID # must be completed. (Item #25 or 33)
- SUPER BILLS SLOW DOWN CLAIM PROCESSING.
- ELECTRONIC CLAIMS SUBMISSION SPEEDS CLAIMS PAYMENT.

PLACE OF SERVICE CODES:


- 41 – Ambulance
- 42 – Ambulance-Air/Water
- 24 – Ambulatory Surgical Center
- 25 – Birthing Center
- 53 – Community Mental Health Center
- 61 – Comprehensive Inpatient Rehab. Facility
- 62 – Comprehensive Outpatient Rehab. Facility
- 33 – Custodial Care
- 52 – Day Care/Psy. Part. Hosp.
- 11 – Doctor's Office
- 23 – Emergency Room Hospital
- 34 – Hospice
- 65 – Independent Kidney Disease Treatment Center
- 81 – Independent Laboratory
- 21 – Inpatient Hospital
- 51 – Inpatient Psych. Facility
- 26 – Military Treatment Facility

- 32 – Nursing Care
- 99 – Other Locations
- 22 – Outpatient Hospital
- 12 – Patient's Home
- 56 – Residential Treatment Center
- 72 – Rural Health Clinic
- 31 – Skilled Nursing Facility
- 54 – Specialized/Intermed./Mental TC
- 71 – State or Local Public Health Clinic

- 8 – Assistant at Surgery
- 9 – Other Medical Service
- 0 – Blood or Packed Red Cells
- A – Used DME
- C – Inpatient Psychiatric Services
- F – Ambulatory Surgical Center
- G – Purchased DME
- H – Hospice
- H – Rental DME
- L – Renal Supplies in the Home
- M – Alternate Payment for Maintenance Dialysis
- M – Vision Care
- N – Kidney Donor
- V – Pneumococcal Vaccine
- V – Hearing Care
- Y – Second Opinion on Elective Surgery
- Z – Third Opinion on Elective Surgery

TYPE OF SERVICE CODES:

- 1 – Medical Care
- 2 – Surgery
- 3 – Consultation (Inpatient only)
- 4 – Diagnostic X-Ray
- 5 – Diagnostic Laboratory
- 6 – Radiation Therapy
- 7 – Anesthesia



DOE, JOHN
Subscriber Name

123456789
Certificate Number

123ABC
Group Number

F 19 4.00/2.00 D 034 12-31-92
Rx Type Chd Age Ded Amt Ag Cd Days Specially Exp Date

ALL Claims should be forwarded to:

Medical Mutual
P.O. Box 6018
Cleveland, OH 44101-1018

PLEASE
DO NOT
STAPLE
IN THIS
AREA



HEALTH INSURANCE CLAIM FORM																			
1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA Form #1)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN or ID)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S 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 (Street No.)						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 (Street No.)							
CITY				STATE				8. PATIENT STATUS Spouse <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE			
ZIP CODE				TELEPHONE (Include Area Code)				Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>				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? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR 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"/>							

PATIENT CLAIM FILING INSTRUCTIONS INFORMATION

1. Use this form for filing claims for reimbursement of all eligible Medical and other expenses eligible under MM insurance programs.
2. Complete all Items #1-10 and 12 and 13 contained in the Patient and Insured Information section, including your signature and date. All the information is essential for prompt and accurate processing of your claim(s).
3. If you are submitting the claim, you must either have the provider (physician) of the services complete the Physician/Supplier Information section of this form, or submit an itemized statement (which should include the information noted).
4. The form must include name of patient, date(s) of service, type of service(s) performed, diagnosis, charge(s) and date(s) symptom first appeared.
5. If the Hospital, Physician or other Health Care Provider is submitting the claim, the Provider/Supplier should complete Items #14-33.
6. If you are submitting a drug claim, be sure to include the prescription drug number and drug name, date of purchase, prescribing doctor and amount charged.
7. Balance due statements cannot be processed and will be returned. We need itemized statements for faster processing and better service.
8. Onset date is required (Item #14), otherwise the claim will be returned.
9. To ensure receipt of your EOB and/or reimbursement, please indicate if there is a change in the insured's mailing address. (Item #7)

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. (Indiana Code IC 27-2-16-3)