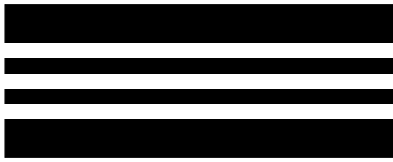


PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 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 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. 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 a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO 10d. RESERVED FOR LOCAL USE 11. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 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. 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) 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. I.D. 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 YES 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

24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. 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.) 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 # PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION