



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <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)																			
6. 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					CITY					STATE																								
ZIP CODE					TELEPHONE (Include Area Code)					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) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY																			
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										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>																			
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, 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. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI _____										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. _____										23. PRIOR AUTHORIZATION NUMBER																			
I. _____ J. _____ K. _____ L. _____										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. EPDCT Family Plan																			
I. ID QUAL										J. RENDERING PROVIDER ID #																													
1										2										3																			
4										5										6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>																			
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. SUPPLIER LOCATION INFORMATION American Medical Center Konrad-Adenauer-Strasse 4 66849 Landstuhl Telefon: 06371 - 49 50 21 Fax: 06371 - 49 50 11										33. BILLING INFORMATION American Medical Center Konrad-Adenauer-Strasse 4 66849 Landstuhl Telefon: 06371 - 49 50 21 Fax: 06371 - 49 50 11																			
SIGNED _____										DATE _____										a. _____																			