



HEALTH INSURANCE CLAIM FORM

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

PICA ☐										PICA ☐									
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA/BLA CLAIM ☐ OTHER ☐										1a. INSURED'S I.D. NUMBER (For Program A Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
CITY										CITY									
STATE										STATE									
ZIP CODE										ZIP CODE									
TELEPHONE (Include Area Code)										TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
10. IS PATIENT'S CONDITION RELATED TO:										12. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
a. EMPLOYMENT? (Current or Previous)										a. INSURED'S DATE OF BIRTH									
b. AUTO ACCIDENT? ☐ YES ☐ NO										b. SEX ☐ M ☐ F									
c. OTHER ACCIDENT? ☐ YES ☐ NO										c. OTHER CLAIM ID (Designated by NUCC)									
15a. CLAIM CODES (Designated by NUCC)										d. INSURANCE PLAN NAME OR PROGRAM NAME									
13. 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										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)										15. OTHER DATE (MM/DD/YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A/L to service the below 21C)										25. OUTSIDE LAB									
A. L. B. L. C. L. D. L.										S. CHARGES									
E. L. F. L. G. L. H. L.										22. REFERRAL CODE									
I. L. J. L. K. L. L. L.										ORIGINAL REF. NO.									
24. A. DATES OF SERVICE										23. PRIOR AUTHORIZATION NUMBER									
B. PLACE OF SERVICE										F. CHARGES									
C. PROCEDURES, SERVICES, OR SUPPLIES										G. DATE OF SERVICE									
D. EXPLANATION OF MEDICAL NECESSITY										H. REFERRAL CODE									
E. DIAGNOSIS										I. DATE OF SERVICE									
F. CHARGES										J. REFERRING PROVIDER'S I.D. #									
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.									
27. SIGNATURE OF PHYSICIAN OR SUPPLIER										27. ACCEPT ASSIGNMENT?									
28. SERVICE FACILITY LOCATION INFORMATION										28. TOTAL CHARGE									
29. BILLING PROVIDER INFO (NPI #)										29. AMOUNT PAID									
30. Read for NUCC Use										30. Read for NUCC Use									

Cms 1500 Form For Workers Compensation

Shasha Hu



Cms 1500 Form For Workers Compensation:

Cms 1500 Form For Workers Compensation Book Review: Unveiling the Power of Words

In some sort of driven by information and connectivity, the energy of words has are more evident than ever. They have the capacity to inspire, provoke, and ignite change. Such is the essence of the book **Cms 1500 Form For Workers Compensation**, a literary masterpiece that delves deep in to the significance of words and their effect on our lives. Compiled by a renowned author, this captivating work takes readers on a transformative journey, unraveling the secrets and potential behind every word. In this review, we will explore the book is key themes, examine its writing style, and analyze its overall effect on readers.

<https://oneclubsober.com/files/browse/Documents/Chants%20Socialists%20William%20Morris.pdf>

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