1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
SFHP ID Number Only

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient's Name (Last, First Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX
MM DD YY M [X] OR F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Insured's Name (Last, First Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
Patient's Address

6. PATIENT RELATIONSHIP TO INSURED
If Applicable
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)
Insured's Address

CITY
City

STATE
State

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY
City

STATE
State

ZIP CODE
Zip Code

TELEPHONE (Include Area Code)
(XXX) XXX-XXXX

ZIP CODE
Zip Code

TELEPHONE (Include Area Code)
(XXX) XXX-XXXX

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
Other Insured's Name

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
Other Insured's Group Name or Policy Number

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX
MM DD YY M [X] OR F [X]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
Employer's Name or School Name

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME
Insurance Plan Name or Program Name

d. INSURANCE PLAN NAME OR PROGRAM NAME
Insurance Plan Name or Program Name

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[X] YES OR [X] NO **If yes**, return to and complete item 9 a-d.

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 _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
Name of Referring Provider or Other Source

17a. *State Medical License #*

17b. NPI *NPI*

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM *MM DD YY* TO *MM DD YY*

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [X] YES OR [X] NO $ CHARGES *XXX XX*

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. **XXX . XX**
2. _____ . _____
3. _____ . _____
4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 *NDC, UPN* **MM DD YY**	**MM DD YY**	**XX**	*X*	**XXXXX**	**XX XX XX**	**XXX.XX**	**XX**	**XX**	*X*	*X* NPI	*Federal Tax ID* *NPI*
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
Federal Tax ID Number [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ **XXX XX**

29. AMOUNT PAID $ *XXX XX*

30. BALANCE DUE $ *XXX XX*

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.)
Signature and Date Required
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Provider Name
Provider Address
City State Zip Code (XXXXXXXXX)
a. **NPI Required** b. *Medi-Cal Provider #*

33. BILLING PROVIDER INFO & PH # **(XXX) XXX-XXXX**
Billing Provider Name
Billing Provider Address
City State Zip Code
a. **NPI Required** b. *Medi-Cal Provider #*