

CLAIMER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA OTHER <input type="checkbox"/> Medicare # <input type="checkbox"/> Medicaid # <input type="checkbox"/> Champion's 2280 <input type="checkbox"/> (Not for use) <input type="checkbox"/> (See Supp. Health Plan) <input type="checkbox"/> (See Supp. Plan) <input type="checkbox"/> (See Supp. Plan) <input type="checkbox"/> (See Supp. Plan) <input type="checkbox"/> (See Supp. Plan)										2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM / DD / YY										4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. PATIENT'S ADDRESS (City, State, ZIP Code)										6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (City, State, ZIP Code)										8. PATIENT'S STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										9. INSURED'S POLICY OR GROUP NUMBER										10. INSURED'S DATE OF BIRTH MM / DD / YY										11. INSURED'S POLICY OR GROUP NUMBER										12. INCIDENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I acknowledge payment of government benefits shall be paid to the party who accepts assignment below. SIGNED: _____ DATE: _____										13. INSURED'S POLICY OR GROUP NUMBER										14. DATE OF CURRENT SERVICE MM / DD / YY										15. IF PATIENT HAS HAD SAME OF SERVICE, GIVE FIRST DATE MM / DD / YY										16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM / DD / YY TO MM / DD / YY										17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM MM / DD / YY TO MM / DD / YY										19. OUTSIDE LAB & CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										20. MEDICAL RESUBMISSION ORIGINAL REF NO. _____										21. PHYSICIAN AUTHORIZATION NUMBER										22. FEDERAL TAX ID NUMBER SSN EIN										23. PATIENT'S ACCOUNT NO.										24. ACCEPT RESPONSIBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO										25. TOTAL CHARGE										26. AMOUNT PAID										27. BALANCE DUE										28. SIGNATURE OF PHYSICIAN OR SUPPLIER I certify that the services on this invoice were rendered and are made subject to the terms and conditions of the contract.										29. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										30. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #									
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Laura Southard Durham

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Healthcare Risk Adjustment and Predictive Modeling Ian G. Duncan,2011

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