{d.insuranceType:fillField('1_insurance_type')}
{d.patient.sex:fillField('3_patient_sex')}
{d.patient.relationshipToInsured:fillField('6_relationship')}
{d.condition.employment:ifEQ(true):show(YES):elseShow(NO):fillField('10a_employme
{d.condition.autoAccident:ifEQ(true):show(YES):elseShow(NO):fillField('10b_auto_acci
{d.condition.otherAccident:ifEQ(true):show(YES):elseShow(NO):fillField('10c_other_ac
{d.insured.sex:fillField('11a_insured_sex')}
{d.insured.hasOtherPlan:ifEQ(true):show(YES):elseShow(NO):fillField('11d_other_plan
{d.outsideLab:ifEQ(true):show(YES):elseShow(NO):fillField('20_outside_lab')}
{d.billingProvider.taxIdType:fillField('25_tax_id_type')}
{d.acceptAssignment:ifEQ(true):show(YES):elseShow(NO):fillField('27_accept_assignm

SPECIMEN

HEALTH INSURANCE CLAIM FORM

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

{d.payer.name:upperCase}
{d.payer.address1:upperCase}
{d.payer.address2:upperCase}
{d.payer.city:upperCase} {d.payer.state} {d.payer.zip}

CARRIER

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
{d.insured.id}

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
{d.patient.lastName:upperCase}, {d.patient.firstNa

3. PATIENT'S BIRTH DATE MM DD YY SEX
{d.pa {d.pa {d.patie M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
{d.insured.lastName:upperCase}, {d.insured.firstName

5. PATIENT'S ADDRESS (No., Street)
{d.patient.street:upperCase}

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
{d.insured.street:upperCase}

CITY
{d.patient.city:upperCase}

STATE
{d.pa

8. RESERVED FOR NUCC USE

CITY
{d.insured.city:upperCase}

STATE
{d.insured

ZIP CODE
{d.patient.zip}

TELEPHONE (Include Area Code)
( )

ZIP CODE
{d.insured.zip}

TELEPHONE (Include Area Code)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
{d.otherInsured.name:upperCase}

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
{d.insured.groupNumber}

a. OTHER INSURED'S POLICY OR GROUP NUMBER
{d.otherInsured.policyNumber}

a. EMPLOYMENT? (Current or Previous)
YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX
{d.in {d.in {d.insu M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)
YES NO {d.co

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?
YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
{d.insured.planName:upperCase}

d. INSURANCE PLAN NAME OR PROGRAM NAME
{d.otherInsured.planName:upperCase}

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO *If yes*, complete items 9, 9a, and 9d.

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 {d.patientSignature:upperCase} 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 {d.insuredSignature:upperCase}

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
{d.cu {d.cu {d.cu QUAL. {d.cu

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
{d.re {d.referringProvider.name:upperCase}

17a.

17b. NPI {d.referringProvider.npi}

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
{d.additionalClaimInfo}

20. OUTSIDE LAB? $ CHARGES
YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. {d.ic

A. {d.diagnose B. {d.diagnose C. {d.diagnose D. {d.diagnose
E. {d.diagnose F. {d.diagnose G. {d.diagnose H. {d.diagnose
I. {d.diagnose J. {d.diagnose K. {d.diagnose L. {d.diagnose

22. RESUBMISSION CODE {d.resubmission.coc ORIGINAL REF. NO. {d.resubmission.originalRef}

23. PRIOR AUTHORIZATION NUMBER
{d.priorAuthorization}

PHYSICIAN OR SUPPLIER INFORMATION

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 {d.lines[0].supplemental}											
{d.lin {d.lin {d.lin	{d.lin {d.lin {d.lin	{d.lin	{d.lin	{d.lines[0	{d.lin {d.lin {d.lin {d.lin	{d.lines	arge:floor}	{d.lin	{d.lin	NPI	{d.lines[0].renderingN
2 {d.lines[1].supplemental}											
{d.lin {d.lin {d.lin	{d.lin {d.lin {d.lin	{d.lin	{d.lin	{d.lines[1	{d.lin {d.lin {d.lin {d.lin	{d.lines	arge:floor}	{d.lin	{d.lin	NPI	{d.lines[1].renderingN
3 {d.lines[2].supplemental}											
{d.lin {d.lin {d.lin	{d.lin {d.lin {d.lin	{d.lin	{d.lin	{d.lines[2	{d.lin {d.lin {d.lin {d.lin	{d.lines	arge:floor}	{d.lin	{d.lin	NPI	{d.lines[2].renderingN
4 {d.lines[3].supplemental}											
{d.lin {d.lin {d.lin	{d.lin {d.lin {d.lin	{d.lin	{d.lin	{d.lines[3	{d.lin {d.lin {d.lin {d.lin	{d.lines	arge:floor}	{d.lin	{d.lin	NPI	{d.lines[3].renderingN
5 {d.lines[4].supplemental}											
{d.lin {d.lin {d.lin	{d.lin {d.lin {d.lin	{d.lin	{d.lin	{d.lines[4	{d.lin {d.lin {d.lin {d.lin	{d.lines	arge:floor}	{d.lin	{d.lin	NPI	{d.lines[4].renderingN
6 {d.lines[5].supplemental}											
{d.lin {d.lin {d.lin	{d.lin {d.lin {d.lin	{d.lin	{d.lin	{d.lines[5	{d.lin {d.lin {d.lin {d.lin	{d.lines	arge:floor}	{d.lin	{d.lin	NPI	{d.lines[5].renderingN

25. FEDERAL TAX I.D. NUMBER SSN EIN
{d.billingProvider.taxId}

26. PATIENT'S ACCOUNT NO.
{d.patient.accountNumbe

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

28. TOTAL CHARGE
${gSum:floor}

29. AMOUNT PAID
{d.lin Paid:floor}

30. Rsvd for NUCC Use
{d.an

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.)
{d.physician.name:upperCase}
SIGNED DATE {d.physicia

32. SERVICE FACILITY LOCATION INFORMATION
{d.serviceFacility.name:upperCase}
{d.serviceFacility.street:upperCase}
{d.serviceFacility.city:upperCase} {d.serviceFac
a. {d.serviceFacility.I b.

33. BILLING PROVIDER INFO & PH # ({d.bil) {d.billingProvider.
{d.billingProvider.name:upperCase}
{d.billingProvider.street:upperCase}
{d.billingProvider.city:upperCase} {d.billingProvider.sta
a. {d.billingProvider.I b.