

PLEASE DO NOT STAPLE IN THIS AREA



CNC/HEALTH CARE SAVINGS PO BOX 2368 Cornelius, NC 28031

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 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 SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. PATIENT STATUS 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

ZIP CODE TELEPHONE (Include Area Code) ( ) 10a. EMPLOYMENT? (CURRENT OR PREVIOUS) 10b. AUTO ACCIDENT? PLACE (State) 10c. OTHER ACCIDENT? 11a. INSURED'S DATE OF BIRTH SEX 11b. EMPLOYER'S NAME OR SCHOOL NAME

10d. RESERVED FOR LOCAL USE 11c. INSURANCE PLAN NAME OR PROGRAM NAME

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 14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE PIN # GRP #

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION