



# HEALTH INSURANCE CLAIM FORM

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

Mail completed forms to:  
Department of Labor and Industries  
PO Box 44269  
Olympia WA 98504-4269

<input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> PICA																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										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 MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE																																		
ZIP CODE					TELEPHONE (Include Area Code) ( )															ZIP CODE					TELEPHONE (Include Area Code) ( )																																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>if yes, complete items 9, 9a, and 9d.</i>																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. RESERVED FOR NUCC USE										c. RESERVED FOR NUCC USE										d. 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. 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 _____																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____										15. OTHER DATE MM DD YY QUAL _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. _____										23. PRIOR AUTHORIZATION NUMBER _____																																																	
24. A. DATE(S) OF SERVICE From DD YY To DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																																											
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Rsvd. for NUCC Use									
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.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.																																							