

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA
PO BOX 45
STILLWATER

PA 12345-0045

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION