MEDICAL CLAIM FORM

PATIENT INFORMATION

1. Patient Name:	2. Patient Date of Birth:	3. Patient ID #:
4. Patient Sex: ☐ Male ☐ Female	5. Patient Phone:	6. Patient Relation to Employee: ☐ Self ☐ Spouse/Domestic Partner ☐ Child ☐ Other
7. Patient Address (Street, City, State, Zip Code): ☐ Check Here if New Address		
8. Insured Name:	9. Insured ID Number:	10. Insured Phone:
11. Insured Address (Street, City, State, Zip Code):		

12. Other Health Insurance Coverage: Is patient covered by any other Health Plan? ☐ Yes ☐ No (If "Yes," complete information below)

Name of Other Carrier: ____________________ Patient Identification #: ____________________

Name of Insured: ____________________ Insured Employer: ____________________

Effective Date of Coverage: ________ Termination Date of Coverage: ________

13. I authorize the undersigned provider to release any information acquired in the course of my examination or treatment.

Signed (Patient or Patient's Legal Guardian if a Minor) Date

PROVIDER INFORMATION

14. Name & Title of Rendering Provider:	
15. Office Address of Rendering Provider:	16. Office Phone of Rendering Provider:

17. Diagnosis or Nature of Illness or Injury (Relate to Procedure Code in Column D):

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Place of Service Codes:

11 – Doctor's Office
72 – Rural Health Clinic
20 – Urgent Care Facility
22 – Outpatient Hospital
21 – Inpatient Hospital
23 – Emergency Room
24 – AMB SURG CTR
31 - Skilled Nursing Facility
32 – Nursing Facility
33 – Custodial Care Facility
41 – Ambulance
51 – INPT PSYCH Facility
52 – PHP PSYCH Facility
53 – Community Mental Health CRT
55 – Substance Abuse RTC
56 – PSYCH RTC
57 – Non-Residential Substance Abuse

18. A-Date of Service: From	To	B-Place of Service	C-Description of Medical Services or Supplies Furnished for Each Date Given (CPT Procedure Code)	D-Diagnosis Code	E-Charges	F-Days or Units

19. Your Patient Account Number:	20. Accepts Assignment (Government Claims Only): ☐Yes ☐No	21. Total Charges:
22. Signature of Provider or Supplier - Including Degree(s) or Credential(s):	23. Tax Identification Number: 24. Taxable Entity Name (If different than Box 25):	25. Provider's, Supplier's, and/or Group Name, Address, Zip Code, & Telephone #: