**HEALTH INSURANCE CLAIM FORM**

**PLEASE PRINT OR TYPE**

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**1. MEDICARE**
- [ ] Medicare (Medicare)
- [ ] Medicare (Medicaid)

**2. PATIENT’S NAME**
- (Last Name, First Name, Middle Initial)

**3. PATIENT’S BIRTH DATE**
- DD

**4. INSURED’S NAME**
- (Last Name, First Name, Middle Initial)

**5. PATIENT’S ADDRESS**
- (No., Street)

**6. PATIENT RELATIONSHIP TO INSURED**
- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Other

**7. INSURED’S ADDRESS**
- (No., Street)

**8. RESERVED FOR NNUC USE**

**9. OTHER INSURED’S NAME**
- (Last Name, First Name, Middle Initial)

**10. IS PATIENT’S CONDITION RELATED TO:**
- [ ] Employment
- [ ] Auto Accident
- [ ] Other

**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, INJURY, OR PREGNANCY (LMP)**
- MM

**15. OTHER DATE**
- MM

**16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**
- MM

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**
- [ ] NPI

**18. HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS**
- FROM

**19. ADDITIONAL CLAIM INFORMATION**

**20. OUTSIDE LAB?**
- [ ] YES
- [ ] NO

**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
- [ ] ICD-10

**22. REBMINON CODE**

**23. PRIOR AUTHORIZATION NUMBER**

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**24. A. DATE(S) OF SERVICE**
- [ ] EPC
- [ ] Table of Service

**25. FEDERAL TAX I.D. NUMBER**

**26. PATIENT’S ACCOUNT NO.**

**27. ACCEPT ASSIGNMENT?**
- [ ] YES
- [ ] NO

**28. TOTAL CHARGE**

**29. AMOUNT PAID**

**30. Resvd for NNUC Use**

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

**32. SERVICE FACILITY LOCATION INFORMATION**

**33. BILLING PROVIDER INFO & PH #**

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**NUCC Instruction Manual available at: www.nucc.org**

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