Medical Business Name Address				MEDICAL BILL			Health Insurance Claim Form						
City. State ZIP DATE: Phone#, web address INVOICE #:													
							Member Information (please print) Last Name First Mil Subcriber ID Number						
								nn – Complete this s		or a qualified dependent			
Bill To: Patient:							Patient Information – Complete this section only if claim is for a qualified dependent. Last Name First MII						
							Patient ID		Date o	f Birth	Relationship		Sex
							Accident Informa	tion – Complete this	s section only if claim is	result of accident or work-related	d illness or		
								first symptoms of ill		e did the accident occur? (City/Sta		/illness related	
Physician			Te	rms	Du	e Date				2.30		to employment? If no, \square Auto \square	
							Describe the accid	Describe the accident or illness.		Give date patient first consulted physician.		Has patient ever had same or similar symptoms? ☐ Yes ☐ No	
					(4/11		Medicare Inform	ation – Complete th	is section only if patien	t is eligible for Medicare.		, ,	
Ot of Service	Description	Total Fee	Co-Pay	Ins Reim	Adj	Balance (PR)		of the "Explanation of the "Explanation of the "Explanation of the Insurance of the Insuran		Number (include any alpha charac	ters) Effective Date Par	t A Effectiv	e Date Part I
) (c)			Other Health Insi	Other Health Insurance – If Yes, complete section below or claim cannot be processed. No other coverage					
							Name of Policyholo	ler	Polic	Number	Name of Insur	ance Company/Ph	none
							Number Street Add	iress		City	State		ZIP
							Assignment of Bo	Patient or authorized person's signeture Assignment of Benefits Lagree to assign benefits directly to the provider of services: Patient or authorized person's signeture Patient or authorized person's signeture					
							T	THIS SECTION FOR PHYSICIAN OR SUPPLIER ONLY. If a detailed statement is available, please attach.					
								Provider Statement of Services Rendered					
							Name and address	of facility where s	ervices were rendered	(if other than home or office)	Date Admitt	ed Date	Discharged
							Diagnosis Code ar 1.	Diagnosis Code and Description 1, 3, 4					
							Date of Service	Place of Service	CPT-4 Procedure	Description of Service	Charges	Days or Units	
					TOTAL		(from/to)		Code	788			
lotes:													
							Signature of Provi	der		y y	Total Charg	e Amount Paid	Balance D
							Provider Name			Tax ID Number			
							Provider Address			Telephone Numb	er ()		