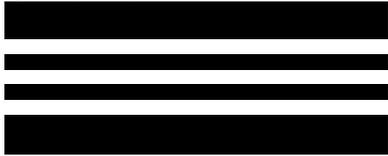


PLEASE DO NOT STAPLE IN THIS AREA



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Health Care

MAIL COMPLETED CLAIM FORM TO THE ADDRESS SHOWN ON YOUR ID CARD

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTHPLAN FECA BLK LUNG OTHER
1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE SEX
4. INSURED'S NAME (LastName, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)
6. PATIENT'S RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No. Street)
8. PATIENT STATUS
9. OTHER INSURED'S NAME (Last Name, First Name, Middle)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Table with 11 columns: A, B, C, D, E, F, G, H, I, J, K. Headers include DATE(S) OF SERVICE, PLACE OF SERVICE, TYPE OF SERVICE, PROCEDURES, SERVICES, OR SUPPLIES, DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSDT Family Plan, EMG, COB, RESERVED FOR LOCAL USE.

24. FEDERAL TAX I.D. NUMBER SSN EIN
25. PATIENT'S ACCOUNT NO.
26. ACCEPT ASSIGNMENT? (For gov't. claims, see back)
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

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