

# WELLCHOICE

PO Box 3509, Church Street Station  
New York NY 10008-3509

CARRIER

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No. Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No. Street)									
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE						
ZIP CODE			TELEPHONE (Include Area Code)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE			TELEPHONE (Include Area Code)						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER NAME OR BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO					d. IS THERE ANOTHER NAME OR BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO									
12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM. READ BACK OF FORM BEFORE COMPLETING THIS FORM. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
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.									
21. 1. _____ 3. _____ 2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER									
A DATE(S) OF SERVICE			B PLACE OF SERVICE	C TYPE OF SERVICE	D PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS MODIFIER				E DIAGNOSIS CODE	F \$ CHARGES		G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE			
1																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS "I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED." SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)					33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMBER PIN# _____ GRP# _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN SUPPLIER INFORMATION

## PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to WellChoice or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any health care provider, payor of health claims, or government agency to furnish to WellChoice or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize WellChoice or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by WellChoice on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.