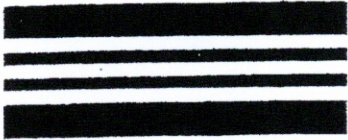


PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA (BLK/LUNG) OTHER

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA (BLK/LUNG) OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
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 (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
24. TABLE with columns: 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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 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)
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Table with columns: 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

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE PINA GRPE