



KEY INSURANCECOMPANY
P.O. BOX 569008

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

MIAMI FL 332560000

PICA		Page 1 of 2		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare#) ☐ (Medicaid#) ☐ (ID#/DoD#) ☐ (Member ID#) ☐ (ID#) ☐ (ID#) ☒ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) JS00111223333			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH TED		3. PATIENT'S BIRTH DATE MM DD YY 05 01 1973 M ☒ F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH JANE	
5. PATIENT'S ADDRESS (No., Street) 237 N MAIN ST		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☒ Other ☐		7. INSURED'S ADDRESS (No., Street) 236 N MAIN ST	
CITY MIAMI		STATE FL		CITY MIAMI	
STATE FL		STATE FL		STATE FL	
ZIP CODE 33413		TELEPHONE (Include Area Code) (555) 5571234		ZIP CODE 33413	
TELEPHONE (Include Area Code) (555) 5561234		TELEPHONE (Include Area Code) (555) 5561234		TELEPHONE (Include Area Code) (555) 5561234	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH JOHN		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO ☐ PLACE (State) c. OTHER ACCIDENT? ☐ YES ☐ NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 2222-SJ	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 000000		a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO		a. INSURED'S DATE OF BIRTH MM DD YY 05 01 1943 M ☐ F ☒	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? ☐ YES ☐ NO ☐ PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? ☐ YES ☐ NO		c. INSURANCE PLAN NAME OR PROGRAM NAME GROUP Name	
d. INSURANCE PLAN NAME OR PROGRAM NAME PLAN NAME		10d. CLAIM CODES (Designated by NUCC) 17 67		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☒ YES ☐ NO If yes, complete items 9, 9a, and 9d.	
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. SIGNED SIGNATURE ON FILE 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 SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 03 12 2018 QUAL 431		15. OTHER DATE QUAL 454 MM DD YY 03 01 2018		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 06 08 2005 TO 06 09 2005	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JONE C DOE		17a. G2 12345 17b. NPI 5234567805		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 05 08 2005 TO 06 08 2005	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NTE ADD SURGERY WAS UNUSUALLY LONG PWK OZ BM DMN0012		20. OUTSIDE LAB? \$ CHARGES ☒ YES ☐ NO 110.00		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. J0300 B. Z1159 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER PriorAuth		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
N400002143481 UN1.01		03 14 05 03 25 05 11 Y 99299 26 27 28 29 AB 40.00 1 Y NPI 1234567804		LU 12345	
10 03 06 10 03 06 11 87099 A 15.00 1 NPI 1234567804		10 03 06 10 03 06 11 99214 B 35.00 1 NPI 1234567804		LU 12345	
N401234567891 UN1.01		10 10 06 10 10 06 11 86663 B 10.00 1 NPI 1234567804		LU 12345	
10 10 06 10 10 06 11 99213 A 20.00 1 NPI 1234567804		10 10 06 10 10 06 11 85025 B 30.00 1 NPI 1234567804		LU 12345	
25. FEDERAL TAX I.D. NUMBER SSN EIN 587654321 ☒		26. PATIENT'S ACCOUNT NO. 36463774		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	
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.) SIGNATURE ON FILE		32. SERVICE FACILITY LOCATION INFORMATION Service Facility 123 FAKE STREET CITY ST 123459999		33. BILLING PROVIDER INFO & PH # (555) 5551234 BEN KILDARE SERVICE 234 SEAWAY ST MIAMI FL 33111	
SIGNED DATE		a. 000000004 b. G212345		a. 9876543210 b. ZZ203BF0100Y	



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CHAMPVA ☐ (Member ID#)		GROUP HEALTH PLAN ☐ (ID#)		FECA BLK LUNG ☐ (ID#)	
OTHER ☒ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)		JS00111223333	
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STATE FL		8. RESERVED FOR NUCC USE		STATE FL	
ZIP CODE 33413		TELEPHONE (Include Area Code) (555) 5571234		ZIP CODE 33413	
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b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME GROUP Name		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☒ YES ☐ NO If yes, complete items 9, 9a, and 9d.	
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17b. NPI 5234567805		20. OUTSIDE LAB? \$ CHARGES ☐ YES ☐ NO		22. RESUBMISSION CODE ORIGINAL REF. NO.	
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24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MODIFIER	
E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	
H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 10 10 06 10 10 06 11 80053 A 45.00 1 LU 12345		NPI 1234567804		2 10 10 06 10 10 06 11 93000 B 55.00 1 LU 12345	
NPI 1234567804		3 NPI		4 NPI	
5 NPI		6 NPI		25. FEDERAL TAX I.D. NUMBER 587654321	
SSN EIN ☒ X		26. PATIENT'S ACCOUNT NO. 36463774		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	
28. TOTAL CHARGE \$ 250.00		29. AMOUNT PAID \$ 79.19		30. Rsvd. for NUCC Use	
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.) SIGNATURE ON FILE		32. SERVICE FACILITY LOCATION INFORMATION Service Facility 123 FAKE STREET CITY ST 123459999		33. BILLING PROVIDER INFO & PH # (555) 5551234 BEN KILDARE SERVICE 234 SEAWAY ST MIAMI FL 33111	
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