

CLAIMER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA OTHER ☐ Medicare # ☐ Medicaid # ☐ Champion's 2280 ☐ (Not for use) ☐ (See back for instructions) ☐ (See back for instructions) ☐ (See back for instructions)		2. PATIENT'S NAME (Last, First, Middle Initial)		3. PATIENT'S BIRTH DATE MM / DD / YY SEX ☐ M ☐ F		4. INSURED'S NAME (Last, First, Middle Initial)		5. INSURED'S ADDRESS (No. Street)									
6. PATIENT'S ADDRESS (No. Street)		7. PATIENT'S STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐		8. PATIENT'S POLICY OR GROUP NUMBER		9. INSURED'S DATE OF BIRTH MM / DD / YY SEX ☐ M ☐ F		10. INSURED'S POLICY OR GROUP NUMBER									
11. OTHER INSURED'S NAME (Last, First, Middle Initial)		12. OTHER INSURED'S DATE OF BIRTH MM / DD / YY SEX ☐ M ☐ F		13. OTHER INSURED'S POLICY OR GROUP NUMBER		14. INSURED'S NAME OF SCHOOL NAME		15. INSURED'S PLAN NAME OR PROGRAM NAME									
16. INSURED'S NAME OF SCHOOL NAME		17. INSURED'S PLAN NAME OR PROGRAM NAME		18. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO <i>If yes, include details below.</i>		19. PHYSICIAN OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I acknowledge payment of government benefits shall be paid to the party who accepts assignment below.)		20. PHYSICIAN OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I acknowledge payment of government benefits shall be paid to the party who accepts assignment below.)									
21. DATE OF CURRENT MM / DD / YY		22. IF PATIENT HAS HAD SAME OF CURRENT ADDRESS GIVE FIRST DATE MM / DD / YY		23. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM / DD / YY TO MM / DD / YY		24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM / DD / YY TO MM / DD / YY		25. OUTSIDE LAB & CHARGES ☐ YES ☐ NO									
26. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		27. I.D. NUMBER OF REFERRING PHYSICIAN		28. MEDICATED RESURGEON CODE		29. PHYSICIAN AUTHORIZATION NUMBER		30. PHYSICIAN AUTHORIZATION NUMBER									
31. PRESERVED FOR LOCAL USE		32. DIAGNOSIS OR NATURE OF ILLNESS (RELATE ITEMS 1-4 TO THIS AREA BY LINE) 1. _____ 2. _____ 3. _____ 4. _____		33. CHARGE CODE A. CHARGES B. CHARGES C. CHARGES D. CHARGES E. CHARGES F. CHARGES G. CHARGES H. CHARGES I. CHARGES J. CHARGES K. CHARGES L. CHARGES M. CHARGES N. CHARGES O. CHARGES P. CHARGES Q. CHARGES R. CHARGES S. CHARGES T. CHARGES U. CHARGES V. CHARGES W. CHARGES X. CHARGES Y. CHARGES Z. CHARGES AA. CHARGES AB. CHARGES AC. CHARGES AD. CHARGES AE. CHARGES AF. CHARGES AG. CHARGES AH. CHARGES AI. CHARGES AJ. CHARGES AK. CHARGES AL. CHARGES AM. CHARGES AN. CHARGES AO. CHARGES AP. CHARGES AQ. CHARGES AR. CHARGES AS. CHARGES AT. CHARGES AU. CHARGES AV. CHARGES AW. CHARGES AX. CHARGES AY. CHARGES AZ. CHARGES BA. CHARGES BB. CHARGES BC. CHARGES BD. CHARGES BE. CHARGES BF. CHARGES BG. CHARGES BH. CHARGES BI. CHARGES BJ. CHARGES BK. CHARGES BL. CHARGES BM. CHARGES BN. CHARGES BO. CHARGES BP. CHARGES BQ. CHARGES BR. CHARGES BS. CHARGES BT. CHARGES BU. 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40. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address and credentials) I certify that the services on this invoice were rendered and are made subject to the terms and conditions of the contract.		41. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		42. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		43. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		44. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		45. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		46. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					

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Family - Apr 21, 2017 — The family Pelobatidae is the European Spadefoot toads but they aren't just found in Europe, they are also found in Asia and Northern Africa.