

## HEALTH INSURANCE CLAIM FORM

<b>1. MEDICARE:</b> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Medicare #) (Medicaid #) (Champion's 2026)		<b>2. PATIENT'S NAME:</b> Last Name, First Name, Middle Initial		<b>3. PATIENT'S BIRTH DATE:</b> MM DD YY	
<b>5. PATIENT'S ADDRESS:</b> (Res., Street)		<b>6. PATIENT'S RELATIONSHIP TO INSURED:</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		<b>7. INSURED'S ADDRESS:</b> (Res., Street)	
<b>8. CITY:</b>		<b>9. PATIENT STATUS:</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		<b>10. CITY:</b>	
<b>11. ZIP CODE:</b>		<b>12. EMPLOYED:</b> Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/>		<b>13. STATE:</b>	
<b>14. TELEPHONE (include Area Code):</b>		<b>15. IS PATIENT'S CONDITION RELATED TO:</b>		<b>16. INSURED'S POLICY GROUP OR PLAN NUMBER:</b>	
<b>17. OTHER INSURED'S NAME:</b> Last Name, First Name, Middle Initial		<b>18. EMPLOYMENT (CURRENT OR PREVIOUS):</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>19. INSURED'S DATE OF BIRTH:</b> MM DD YY	
<b>19. OTHER INSURED'S POLICY OR GROUP NUMBER:</b>		<b>20. AUTO ACCIDENT?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>21. EMPLOYER'S NAME OR SCHOOL NAME:</b>	
<b>22. OTHER INSURED'S DATE OF BIRTH:</b> MM DD YY		<b>23. OTHER ACCIDENT?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>24. INSURANCE PLAN NAME OR PROGRAM NAME:</b>	
<b>23. EMPLOYER'S NAME OR SCHOOL NAME:</b>		<b>24. IS THERE ANY OTHER HEALTH BENEFIT PLAN?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, indicate and complete item 24a		<b>25. INSURED'S POLICY OR AUTHORIZED PERSON'S SIGNATURE:</b> I authorize the release of any medical or other information necessary to process this claim. I acknowledge payment of government benefits either to myself or to the party who accepts assignment herein.	
<b>24. INSURANCE PLAN NAME OR PROGRAM NAME:</b>		<b>25. IS THERE ANY OTHER HEALTH BENEFIT PLAN?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, indicate and complete item 24a		<b>26. INSURED'S POLICY OR AUTHORIZED PERSON'S SIGNATURE:</b> I authorize the release of any medical or other information necessary to process this claim. I acknowledge payment of government benefits either to myself or to the party who accepts assignment herein.	
<b>26. SIGNED:</b>		<b>27. DATE:</b>		<b>28. SIGNED:</b>	
<b>27. DATE OF CURRENT CLAIM:</b> MM DD YY		<b>29. IF PATIENT HAS HAD SAME OR DIFFERENT ADDRESS SINCE FIRST DATE:</b> MM DD YY		<b>30. DID PATIENT MOVE TO WORK IN CURRENT OCCUPATION?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>28. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:</b>		<b>31. (C) NUMBER OF REFERRED PHYSICIAN:</b>		<b>32. HOSPITALIZATION DATES RELATED TO CURRENT REFERRAL:</b> MM DD YY	
<b>29. RESERVED FOR LOCAL USE:</b>		<b>33. OUTSIDE LAST:</b>		<b>34. CHARGES:</b>	
<b>30. CHARGES OR NATURE OF ILLNESS OR INJURY (RELATE ITEM 33a TO ITEM 34b BY LINE):</b>		<b>35. MEDICARE REDEMPTION CODE:</b>		<b>36. ORIGINAL REF NO.</b>	
<b>31. CHARGES:</b>		<b>32. ORIGINAL REF NO.</b>		<b>33. PRIOR AUTHORIZATION NUMBER:</b>	
<b>32. PRIOR AUTHORIZATION NUMBER:</b>		<b>34. CHARGES:</b>		<b>35. DATE OF LAST CHARGE:</b>	
<b>33. CHARGES:</b>		<b>36. DATE OF LAST CHARGE:</b>		<b>37. SPECIAL PAYMENT PLAN:</b>	
<b>34. CHARGES:</b>		<b>37. SPECIAL PAYMENT PLAN:</b>		<b>38. EMG CODE:</b>	
<b>35. CHARGES:</b>		<b>38. EMG CODE:</b>		<b>39. CODE:</b>	
<b>36. CHARGES:</b>		<b>39. CODE:</b>		<b>40. RESERVED FOR LOCAL USE:</b>	
<b>40. RESERVED FOR LOCAL USE:</b>		<b>41. FEDERAL TAX ID NUMBER:</b>		<b>42. PATIENT'S ACCOUNT NO.</b>	
<b>41. FEDERAL TAX ID NUMBER:</b>		<b>42. PATIENT'S ACCOUNT NO.</b>		<b>43. ACCOUNT ASSIGNMENT?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>42. PATIENT'S ACCOUNT NO.</b>		<b>43. ACCOUNT ASSIGNMENT?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>44. TOTAL CHARGE:</b>	
<b>43. ACCOUNT ASSIGNMENT?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>44. TOTAL CHARGE:</b>		<b>45. AMOUNT PAID:</b>	
<b>44. TOTAL CHARGE:</b>		<b>45. AMOUNT PAID:</b>		<b>46. BALANCE DUE:</b>	
<b>45. AMOUNT PAID:</b>		<b>46. BALANCE DUE:</b>		<b>47. PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE &amp; PHONE #</b>	
<b>46. BALANCE DUE:</b>		<b>47. PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE &amp; PHONE #</b>		<b>48. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDES DEGREE OR CREDENTIALS)</b>	
<b>47. PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE &amp; PHONE #</b>		<b>48. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDES DEGREE OR CREDENTIALS)</b>		<b>49. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office):</b>	
<b>48. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDES DEGREE OR CREDENTIALS)</b>		<b>49. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office):</b>		<b>50. SIGNED:</b>	
<b>49. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office):</b>		<b>50. SIGNED:</b>		<b>51. DATE:</b>	

# Place Of Service Codes For Hcfa 15

**United States. Congress. Senate.  
Committee on Finance. Subcommittee  
on Medicare and Long-Term Care**

**Place Of Service Codes For Hcfa 15:**

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