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

1. [Medicare] [Medicaid] [TRICARE] [CHAMPVA] [GROUP HEALTH PLAN] [FECA] [OTHER]
[ ] (Medicare), [ ] (Medicaid), [ ] (Tricare), [ ] (Champva), [ ] (Group Health), [ ] (Feca), [ ] (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
[ ] Self, [ ] Spouse, [ ] Child, [ ] Other

7. INSURED'S ADDRESS (No., Street)

8. ZIP CODE [ ] CITY, [ ] STATE

9. TELEPHONE (Include Area Code)

10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

11. IS PATIENT'S CONDITION RELATED TO
a. EMPLOYMENT? (Current or Previous) [ ] YES, [ ] NO
b. AUTO ACCIDENT? [ ] YES, [ ] NO
c. OTHER ACCIDENT? [ ] YES, [ ] NO

d. INSURANCE PLAN NAME OR PROGRAM NAME)