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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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PATIENT AND INSURED INFORMATION

1. MEDICARE ◯ (Medicare #) MEDICAID ◯ (Medicaid #) TRICARE CHAMPUS ◯ (Sponsor's SSN) CHAMPVA ◯ (Member ID#) GROUP HEALTH PLAN ◯ (SSN or ID) FECA BLK LUNG ◯ (SSN) OTHER ◯ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
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)
CITY / STATE	8. PATIENT STATUS Single ◯ Married ◯ Other ◯ Employed ◯ Full-Time Student ◯ Part-Time Student ◯	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ◯ NO ◯	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ◯ F ◯
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ◯ F ◯	b. AUTO ACCIDENT? YES ◯ NO ◯ PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ◯ NO ◯	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ◯ NO ◯ ***If yes***, return to and complete item 9 a-d.
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 _____ 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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ◯ NO ◯ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. ____ . ____ 3. ____ . ____ 2. ____ . ____ 4. ____ . ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ◯ EIN ◯	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ◯ NO ◯	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.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

NUCC Instruction Manual available at: www.nucc.org

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4. VCGCB may disclose your personal information to another requestor, only if required to do so by law or in good faith that such action is necessary to:
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9. The information collected is used by the California Victim Compensation Program.
10. Any questions regarding the information collected, please write to the following address: 400 R Street, 5th Floor Sacramento, CA 95811, email info@vcgcb.ca.gov, call (800) 777-9229, or contact the VCGCB Privacy Coordinator at InfoSecurityandPrivacy@vcgcb.ca.gov.
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