[redacted]

Empire BlueCross BlueShield
POB 1407
CHURCH STREET STATION,
NEW YORK, NY 10008-1407

APPROVED OMB-0938-0008

**NOTE: Important filing instructions on next page.**

PICA

# HEALTH INSURANCE CLAIM FORM MEMBER SUBMITTED

PICA

CARRIER

PATIENT AND INSURED INFORMATION

| | | |
|---|---|---|
| 1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) 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. and Street) | 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ | 7. INSURED'S ADDRESS (No. and 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 | d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER NAME OR BENEFIT PLAN? ☐ YES ☐ NO If YES, return to and complete item 9a–d. |

**READ BACK OF FORM BEFORE COMPLETING THIS SECTION.**

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM.

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 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 TO MM DD YY |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 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 TYPE OF SERVICE | D PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT FAMILY PLAN | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | 99386 | | 148 00 | | 142. | 45 | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO | 27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. BALANCE DUE $ |
|---|---|---|---|---|---|
| 34 1839775 ☐ ☒ | | | | | 5 55 |

| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER, INCLUDING DEGREES OR CREDENTIALS I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED. SIGNED DATE | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | 33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE NUMBER Life Line Screening Attn: Accounts Receivable 901 South Mo Pac Expressway #2, Suite 130 Austin, TX 78746 PIN# GRP# |
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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500

PHY 0744E-CDF 9/04