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HEALTH INSURANCE CLAIM FORM PICA  HEALTH INSURED S ID NUMBER FECA OTHER 1s INSURED S ID NUMBER (Last Name, First Name, Middle Initial)  SPATIENTS ADDRESS (No. Street) FIRST INSURED S NAME (Last Name, First Name, Middle Initial)  STATE STATE STATE STATE STATE STATE SINGLE DOWN FELEPHONE (Indude Area Code) Fire InsureD S NAME (Last Name, First Name, Middle Initial)  STATE STATE SINGLE DOWN FIRST STATUS Single Married Other Control FIRST INSURED S NAME (Last Name, First Name, Middle Initial)  STATE STATE SINGLE DOWN FIRST STATUS Single Married Other Control FIRST INSURED S NAME (Last Name, First Name, Middle Initial)  STATE STATE SINGLE DOWN FIRST STATUS Single Married Other Control FIRST INSURED S NAME (Last Name, First Name, Middle Initial)  STATE STATE STATE SINGLE DOWN FIRST STATUS Single Married Other Control FIRST INSURED S NAME (Last Name, First Name, Middle Initial)  STATE STATE SINGLE DOWN FIRST STATUS Single Married Other Control FIRST STATUS SINGLE STATUS SING	DATE(S) OF SERVICE Place Type PROC	D E EDURES, SERVICES. OR SUPPLIES DIAGNOSIS	DAYS E	PSDT	RESERVED FOR	
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HEALTH INSURANCE CLAIM FORM PICA  HEALTH INSURANCE CLAIM FORM PICA  HEALTH INSURANCE CLAIM FORM PICA  HEALTH INSURANCE CLAIM FORM  PICA  HEALTH INSURANCE CLAIM FORM  PICA  HEALTH INSURANCE CLAIM FORM  It is insured so to the program in titled to the party who accepts assignment of process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment in also request payment of government benefits either to myself or to the party who accepts assignment in also request payment of government benefits either to myself or the party who accepts assignment in party in the party in the party in the party who accepts assignment in party in the undersigned physician or supplier for payment of the party who accepts assignment in the party in the party in the party in the party in the payment of government benefits either to myself or to the party who accepts assignment in the party in the payment of government benefits either to myself or to the party who accepts assignment in the undersigned physician or supplier for payment of the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the undersigned physician or supplier for payment of the party who accepts assignment in the party in the party in the party who accepts assignment in the undersigned physician or supplier for payment of paymenter to myself or to the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the party in the party who accepts assignment in the party						
HEALTH INSURANCE CLAIM FORM  PICA  HEALTH INSURANCE CLAIM FORM  PICA  MEDICARE MEDICARD CHAMPUS CHAMPU						
PICA			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY			
PICA	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR	(First symptom) OR		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		
HEALTH INSURANCE CLAIM FORM  PICA  HEALTH INSURED S ID. NUMBER (FOR PROGRAM IN ITEM 1)  HEALTH PLAN BLY LUNG  (SSN or ID) (SSN or ID) (ID)  ATTENT'S NAME (Last Name, First Name, Middle Initial)  ATTENT'S NAME (Last Name, First Name, Middle Initial)  ATTENT'S ADDRESS (No., Street)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  ATTENT'S ADDRESS (No., Street)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  ATTENT'S ADDRESS (No., Street)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  BY ATTENT'S BIRTH DATE DEST NAME (Last Name, First Name, Middle Initial)  CODE  TELEPHONE (Include Area Code)  Employed Full-Time Part-Time Student  Sudent Student  THER 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. INSURED'S DATE OF BIRTH  SEX  WM DO WM F  DEST NAME OR SCHOOL NAME  DEMPLOYER'S NAME OR SCHOOL NAME  D. AUTO ACCIDENT?  PLACE (State)  D. EMPLOYER'S NAME OR SCHOOL NAME  D. EMPLOYER'S NAME OR SCHOOL NAME  O. OTHER ACCIDENT?  VES NO  O. INSURANCE PLAN NAME OR PROGRAM NAME  10d. RESERVED FOR LOCAL USE  O. IS THERE ANOTHER HEALTH BENEFIT PLAN?  VES NO  West Date of the Total Name or PROGRAM NAME  A. INSURED'S ID. NUMBER (Last Name, First Name, First Name, First Name, Middle Initial)  THERE INSURED'S DATE OF BIRTH  SEX  DATE OF THE NAME OR PROGRAM NAME  D. EMPLOYER'S NAME OR SCHOOL NAME  D.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize o process this claim. I also request payment of government benefits below.	ze the release of any medical or other information necessary either to myself or to the party who accepts assignment	payment of medical benefits services described below.			
PICA   HEALTH INSURANCE CLAIM FORM   PICA   MEDICARE			YES NO If yes, return to and complete item 9 a.d.			
PICA   HEALTH INSURANCE CLAIM FORM   PICA   MEDICAID   CHAMPUS		YES NO				
PICA   HEALTH INSURANCE CLAIM FORM   PICA   MEDICAID   CHAMPUS   CHAMPVA   GROUP   FECA   OTHER   1a. INSURED'S I.D. NUMBER   (FOR PROGRAM IN ITEM 1)   (Sponsor's SSN)   (VA File #)   (SSN)   (ID)	M DD YY M F	YES NO	b. EMPLOYER'S NAME OR SCHOOL NAME			
HEALTH INSURANCE CLAIM FORM  PICA  MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (Medicare #) (Medicare #) (Sponsor's SSN) (VA File #) (SSN or ID) (ID)  ATIENT'S NAME (Last Name, First Name, Middle Initial)  3. PATIENT'S BIRTH DATE SEX MM F CONTINUED TO INSURED TO INSURED SOURCE (No., Street)  4. INSURED'S NAME (Last Name, First Name, Middle Initial) TO INSURED TO INSURED TO INSURED SOURCE (No., Street)  5. Self Spouse Child Other Single Married Other Structure Single Married Student St	YES NO		MM DD YY			
HEALTH INSURANCE CLAIM FORM  MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)  ATIENT'S NAME (Last Name, First Name, Middle Initial)  ATIENT'S ADDRESS (No., Street)  6. PATIENT SEITH DATE MM F TO INSURED STATE Spouse Child Other  STATE Spouse Child Other  TELEPHONE (Include Area Code)  ( )		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROU	P OR FECA NUME	BER	
PICA  MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (SSN or ID) (SSN or ID) (SSN) (ID)  ATIENT'S NAME (Last Name, First Name, Middle Initial)  ATIENT'S ADDRESS (No., Street)  STATE 8. PATIENT STATUS  HEALTH INSURANCE CLAIM FORM  PICA  OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  4. INSURED'S NAME (Last Name, First Name, Middle Initial)  7. INSURED'S ADDRESS (No., Street)  STATE  STATE  STATE	CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (II	NCLUDE AREA CODE)	
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PICA  MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN BLK LUNG (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)  HEALTH INSURANCE CLAIM FORM  PICA  OTHER BLK LUNG (ISSN) (ID)  The control of the cont	ATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Nam	ne, First Name, Mic	ldle Initial)	
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