



# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>																																		
1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA BLK LUNG <input type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																								
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																								
CITY					STATE					8. RESERVED FOR NUCC USE																								
ZIP CODE					TELEPHONE (Include Area Code) ( )					CITY																								
STATE					STATE					STATE																								
ZIP CODE					TELEPHONE (Include Area Code) ( )					ZIP CODE																								
TELEPHONE (Include Area Code) ( )					TELEPHONE (Include Area 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) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>																								
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)																								
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																								
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>										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 _____					SIGNED _____																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY    QUAL _____					15. OTHER DATE MM DD YY    QUAL _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
17b. NPI _____					17d. NPI _____					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO    \$ CHARGES _____																								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)    ICD Ind. _____										23. PRIOR AUTHORIZATION NUMBER _____																								
A. _____		B. _____		C. _____		D. _____		E. _____		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #																
E. _____		F. _____		G. _____		H. _____		I. _____		J. _____		K. _____		L. _____																				
I. _____		J. _____		K. _____		L. _____																												
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														
1					2					3					4					5					6									
25. FEDERAL TAX I.D. NUMBER					SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use				
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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ( )														
SIGNED _____					DATE _____					a. NPI _____					b. NPI _____					a. NPI _____					b. NPI _____									

## Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits you have available, we *require* you to contact your insurance company at the phone number listed on your insurance card, and ask (and enter below) the following information. **Failure to fill this form out COMPLETELY will disable us from billing your insurance provider for services rendered. It is your responsibility to pay for any outstanding balance.** Psychological Services and Therapy is a *confidential* process to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentiality may be compromised.

Once you have filled this form out, please return as soon as possible. Please ask the following questions.

**“I AM CALLING TO CHECK MY PSYCHOTHERAPY BENEFITS.”**  
(Be sure you are transferred to the mental health department, not medical)

1. Is Dr. Valerie Maxwell a provider under my plan?      Yes / No
2. Deductible (if none, enter “0”): \$ \_\_\_\_\_
  - a. (If #2 is *not* 0) Has the Deductible been met?      Yes / No
3. Do I need an authorization for mental health?      Yes / No
  - a. (If #3 is Yes) What is the authorization number? \_\_\_\_\_
  - b. (If you have an authorization #) How many sessions are authorized to start? \_\_\_\_\_
  - c. What is the start and end dates of the authorized sessions? Start \_\_\_\_\_ End \_\_\_\_\_
4. What is the maximum number of sessions I’m authorized to use? \_\_\_\_\_
5. What is my co-payment? \_\_\_\_\_
6. Address to send Mental Health Claims:      7. Address to send Treatment Reports (to Insurance Co):  
 \_\_\_\_\_  
 \_\_\_\_\_
8. Phone # Called: \_\_\_\_\_      Date of Call: \_\_\_\_\_

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Client Name (Print)