



**Oxford** 

## ALTH INSURANCE CLAIM FORM

Attn: Claims Department P.O. Box 29130

Sed   Spools   Child   Ohw	APPHOVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUC	Hot Springs, AR 71903		PICA
PATIENT'S NAME (DAM Name, Prof Name, Mode brisis)		HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
PATIENT'S ADDRESS (No. 5 the M)  DEPTONE CONTROL OF THE PROPERTY OR SURED  THE PROPERTY OR		(Member ID#) (ID#) (ID#)	4 INCLIDED'S NAME (Lost Name	Cleat Name Middle Initially
Sed Score Code Only STATE  P CODE TELEPHONE (Include Ansa Code)  (	2. FATERT O PANE (Last Pane, First Pane, Middle IIIIIa)		4. INSURED S NAME (Last Name	e, First Name, Middle Initial)
TOTHER NEURED'S POLICY OR GROUP HUMBER    POCOSE	5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., S	itreet)
P CODE    TELEPHONE (houde Ans Code)   TELEPHONE (houde Ans Code)				
PATENTS OR AUTHORIZED PERSONS SIGNATURE:   authorizes and significant this Formation (assignment)	CITY	STATE 8. RESERVED FOR NUCC USE	CITY	STATE
PATENTS OR AUTHORIZED PERSONS SIGNATURE:   authorizes and significant this Formation (assignment)	ZIP CODE TELEPHONE (Include Area Co	ode)	ZIP CODE	TELEPHONE (Include Area Code)
PATENTS OR AUTHORIZED PERSONS SIGNATURE:   authorizes and significant this Formation (assignment)	( )			( )
PATENTS OR AUTHORIZED PERSONS SIGNATURE:   authorizes and significant this Formation (assignment)	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	
PATENTS OR AUTHORIZED PERSONS SIGNATURE   authorizes personnel brended or other information recessary before the date. I also request payment of provement brended is other to he party who accepts assignment	a OTHER INSURED'S POLICY OR GROUP NUMBER		- INCLIDED OF DATE OF DIDTH	
PATENTS OR AUTHORIZED PERSONS SIGNATURE   subcitate the release of any medical or other information necessary below.   SIGNATURE   subcitate the release of any medical or other information necessary below.   SIGNATURE   subcitate the release of any medical profile information necessary below.   SIGNATURE   subcitate the release of any medical or other information necessary below.   SIGNATURE   subcitate the release of any medical or other information necessary below.   SIGNATURE	a official to the state of the		MM DD YY	
READ BACK OF PORM BEPORE COMPLETING A SIGNING THIS FORM.  PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I subcritate has released of my medical or other information recessary below.  SIGNED DATE  SIGNED DATE  OUAL MM DO YY  NM DO TY SIGNATURE OF ILLNESS, NAURY, or PRECNANCY (LMP) IS, OTHER DATE  OUAL MM DO YY  NAME OF REFERRING PROVIDER OR OTHER SOURCE  178.  PROMITED SIGNATURE OF ILLNESS, NAURY, or PRECNANCY (LMP) IS, OTHER DATE  OUAL NAME OF REFERRING PROVIDER OR OTHER SOURCE  179.  PRODUCTIONAL CLAIM INFORMATION (Designated by NUCC)  1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (RME)  D. DATE  SIGNED  OUAL SIGNATURE OF ILLNESS OR INJURY Relate A-L to service line below (RME)  D. DATE OF CONTROL OF SERVICE SIGNATURE OF ILLNESS OR INJURY Relate A-L to service line below (RME)  D. DATE OF CONTROL OF SERVICE SIGNATURE OF ILLNESS OR INJURY Relate A-L to service line below (RME)  D. DATE OF SERVICE SIGNATURE OF ILLNESS OR INJURY Relate A-L to service line below (RME)  D. DATE OF SERVICE SIGNATURE OF ILLNESS OR INJURY Relate A-L to service line below (RME)  D. D	b. RESERVED FOR NUCC USE	h AUTO ACCIDENT?	b. OTHER CLAIM ID (Designated	
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2. PATENTS OR AUTHORIZED PERSON'S SIGNATURE I authorizes the release of any medical or other information necessary to process this claim. I also requise payment of government handles either to myself or to the party who accepts assignment before the process of	Tou. Outlin Could be against by NOCO)			
to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED  DATE  SIGNED  DATE  SIGNED  OUAL.  OUAL.  TO MAN DD YY  TO MON MON TO MO	READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the release of any medical or other information persessor.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize	
SIGNED  DATE  SIGNED  LOATES PATIENT LINESS, INJURY, or PREGNANCY (LMP)  QUAL  OUAL  OUAL  OUAL  TO  OUAL  TO  OUAL  TO  OUAL  TO  TO  TO  TO  TO  TO  TO  TO  TO  T	to process this claim. I also request payment of government bene	afits either to myself or to the party who accepts assignment		and undersigned physician or supplier for
A DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)  JOUAL  JOU	SIGNED		SIGNED	
QUAL   FROM	14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE			
17b, NP    FROM   D	QUAL. QUAL.		FROM TO	
29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Pictate A-L to service line below (24E)  12. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Pictate A-L to service line below (24E)  13. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Pictate A-L to service line below (24E)  14. A. DATE(S) OF SERVICE  15. C. D. D. C. D. H. L.	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		MM DD YY	MM DD YY
	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
A. L. B. C. L. D. L. J. L. K. L. L. L. S. PRIOR AUTHORIZATION NUMBER  E. F. J. G. L. H. L.				
B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Insusal Circumstances) DIAGNOSIS SCHARGES UNITS PROVIDER ID. DAYS PROVIDED ID. DAYS PR	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	-L to service line below (24E) ICD Ind.		ORIGINAL REF. NO.
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4. A. DATE(S) OF SERVICE FROM FOOD FOOD FROM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER  DIAGNOSIS CPT/HCPCS MODIFIER DIAGNOSIS SCHARGES DIAGNOSIS PRIVITE NPI NPI NPI NPI  1. J.		G. L. H. L.	23. FRIOR AUTHORIZATION NO	MIDER
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER \$ CHARGES UNTS Filter QUAL PROVIDERID. #  NPI  NPI  NPI  5. FEDERAL TAX.I.D. NUMBER SSN EIN 1. SIGNATURE OF PHYSICIAN OR SUPPLIER SO CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  A COLUMN PRIVATE OF PHYSICIAN OR SUPPLIER SIGNATURE SIGNAT	24. A: DATE(S) OF SERVICE B. C. D	D. PROCEDURES, SERVICES, OR SUPPLIES E.	F. G.	EDENT
5. FEDERAL TAX I.D. NUMBER SSN EIN  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT? [For govt. claims, see back)  YES NO \$  1. 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 # ( )			OR	Family ID.   NENDERING
5. FEDERAL TAX I.D. NUMBER SSN EIN  26. PATIENT'S ACCOUNT NO.  27. ACCEPT ASSIGNMENT? [For govt. claims, see back)  YES NO \$  1. 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 # ( )				
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INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	YES NO		\$2.	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	INCLUDING DEGREES OR CREDENTIALS		33. BILLING PROVIDER INFO &	PH# ( )
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IGNED DATE a. ND b. a. ND b.				
	SIGNED DATE	NPI b	a. ND b.	