[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 / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☒ (SSN or ID) ☐ (SSN) ☐ (ID)	Enter Empire ID#
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Jane	3. PATIENT'S BIRTH DATE: 06 / 30 / 77 — SEX: M ☐ F ☒
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Participant's Information	
5. PATIENT'S ADDRESS (No. and Street): 123 Main Street	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐
7. INSURED'S ADDRESS (No. and Street): Enter Information	
CITY: Anytown — STATE: CA	8. PATIENT STATUS: Single ☐ Married ☒ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐
CITY — STATE	
ZIP CODE: 12345 — TELEPHONE (Include Area Code): 999 999-9999	
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? PLACE (State) ☐ YES ☐ NO
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. 300.01 2. F41.1 3. 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 6 25 13				90834			180 00					
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
30-0000000000 ☐ ☐			$ 180.00	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER, INCLUDING DEGREES OR CREDENTIALS	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
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.		ABC HEALTH ASSOCIATES 1 Main Street Anytown, CA 90000
SIGNED DATE		PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

FILING INSTRUCTIONS

MEMBERS: You are required to complete this claim form if you receive services from a nonparticipating physician (any physician that is "out-of-network").

1. Complete the patient and insured information sections **(Boxes 1–12)**.
   - Please make sure the three-letter alpha prefix, along with the insured's member identification number, appears in **Box 1a. Do not complete Box 13**.
2. Attach the original itemized bill from the physician to the claim form and mail it to the address listed on the front of the form.

   OR

   Have the physician complete the physician supplier information sections **(Boxes 14–33).** And mail it to the address listed on the front of the form.

NOTE: If you receive services from a participating physician (an "in-network" physician), you are not required to complete any claim forms. All participating network physicians submit claims directly to their local Blue Cross and/or Blue Shield plan.

If you have any questions about completing this claim form, please call the Customer Service telephone number listed on the front of the form or the number on the back of your member identification card.

PROVIDERS: If you have rendered services to a member, please complete the physician supplier information sections **(Boxes 14–33)**. Then mail it to the address listed on the front of the form.

PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to Empire or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any healthcare provider, payor of health claims or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, or payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act punishable under law and may be subject to civil penalties.