

Health Insurance Claim Form

Make copies as needed for youth **under 18**. Team leader keeps copies in his or her possession.

DO NOT SEND THIS FORM TO HENDERSON SETTLEMENT!

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| <ol style="list-style-type: none"> 1. Name of insured person on insurance card, usually father or mother. 2. Address of insured person on insurance card if different than patient's address. 3. Identification number or policy number from insurance card, usually the social security of the insured parent or patient if employed adult 4. Group number on insurance card. 5. Insured cardholder's birthdate 6. Does patient have other insurance coverage, such as coverage under two different insurances by both parents? If so, which is the primary insurer? | <ol style="list-style-type: none"> 7. Please attach a clear copy of both front and back of insurance card. (Make sure that the phone number is legible. 8. We also need a parent's signature authorizing release of medical or other information necessary to process an insurance claim. 9. We need a parent's signature authorizing payment of medical benefits to the physician for services rendered. 10. We need a parent's signature giving permission for treatment of a minor child (under 18). |
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PLEASE
DO NOT
STAPLE
IN THIS
AREA



Name, Address, City, State, Zip and Phone number of Insurance Company

HEALTH INSURANCE CLAIM FORM

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)
<input type="checkbox"/> Medicare #	<input type="checkbox"/> Medicaid #	<input type="checkbox"/> Sponsor's SSN	<input type="checkbox"/> O./A Fib #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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)
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. PATIENT STATUS: Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
ZIP CODE		TELEPHONE (Include area code)		Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/>		STATE	
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	
b. OTHER INSURED'S DATE OF BIRTH M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d	
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 to either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment or medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____						SIGNED _____	
DATE _____							