HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME | SEX M F

Box 4: Enter the subscriber's name.

Box 11: IMPORTANT: Please be sure to enter the employer group name the client is using the EAP benefits though in box 11. For example, a client may be using EAP benefits though a spouse's employer.

Box 11A: Enter the subscriber's date of birth

Box 11C: Enter WellSpan EAP

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Enter subscriber's name

5. PATIENT'S ADDRESS | TO INSURED | Other
7. INSURED'S ADDRESS (No., Street)

CITY | CITY | STATE

ZIP CODE | ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S | N RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
Enter employer group name

a. OTHER INSURED'S | or Previous) | NO
a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR N | PLACE (State) | NO
b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR N | NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
WELLSPAN EAP

d. INSURANCE PLAN | ated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

Please use this guide when completing your claim form to ensure it will be processed correctly.

Electronic Payor code for WellSpan EAP is CB457

Mail or fax claim form to:
WellSpan EAP
Attn: Client Services Department
P.O. Box 1827
York, PA 17405-1827
FAX: 717-851-4493

12. | r information necessary | accepts assignment

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

14. | DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19.
20. OUTSIDE LAB? YES NO | $ CHARGES

21. | Ind.
22. RESUBMISSION CODE | ORIGINAL REF. NO.

A | D. | E | H. | I. | L.
23. PRIOR AUTHORIZATION NUMBER

24. | UPPLIES | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

Line	Procedure	ID. QUAL.
1	90791	NPI
2	90834	NPI
3	90846	NPI
4	90847	NPI
5		NPI
6		NPI

Please use 90791 for initial visit and 90834 and 90837 for subsequent visits. Use 90846 or 90847 for family/ couples. You may put multiple visits on one form.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org | ***PLEASE PRINT OR TYPE*** | APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form