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)

Enter eight zeros or eight nines: 00000000 or 99999999

2. PATIENT'S NAME

SEX M F

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 STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S ...

... 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 ...

PLACE (State) NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR ...

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.

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

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

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

14. ... DD YY

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

17. ...

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

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

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.

PATIENT AND INSURED INFORMATION

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.

Clear Form