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!

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?
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).

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ Medicare # MEDICAID ☐ Medicaid # CHAMPUS ☐ Sponsor's SSN CHAMPVA ☐ 0/A Fib #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN OTHER ☐ (ID)		1a. INSURED'S I D NUMBER (FOR PROGRAM IN ITEM 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. Patient's BIRTH DATE MM DD YY |____|____|____| SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
City STATE	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE TELEPHONE (Include area code) ( )	Employed ☐ Full Time Student ☐ Part Time Student ☐	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 SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) |____|	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	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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. SIGNED _____ DATE _____		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 _____

Form updated 3/99