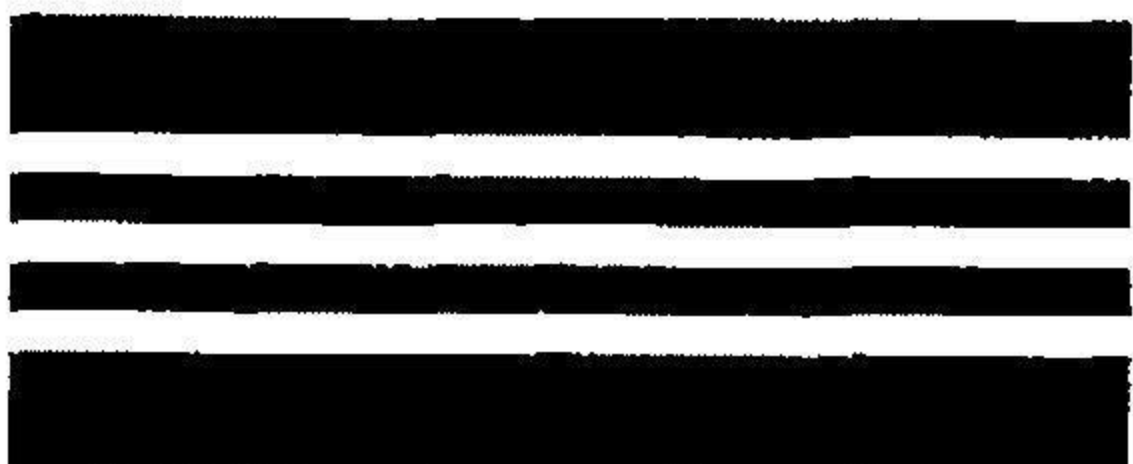


PLEASE DO NOT STAPLE IN THIS AREA



ACHIA  
FIRST CHOICE - ACHIA  
BEECHSTREET WRAP  
PO BOX 2289  
SEATTLE, WA 98111-2289

CARRIER

HEALTH INSURANCE CLAIM FORM

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|   |  |  |  |
|---|--|--|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/><br>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (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<br>MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>  |  |
| 5. PATIENT'S ADDRESS (No., Street)  |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>  |  |
| CITY STATE  |  | 7. INSURED'S ADDRESS (No., Street)   |  |
| ZIP CODE TELEPHONE (Include Area Code)  |  | CITY STATE   |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)   |  | 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/><br>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/><br>b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/><br>c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>BMI190  |  |
| c. EMPLOYER'S NAME OR SCHOOL NAME   |  | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>  |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME  |  | b. EMPLOYER'S NAME OR SCHOOL NAME  |  |
| 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 either to myself or to the party who accepts assignment below.<br>SIGNED _____ DATE _____   |  | c. INSURANCE PLAN NAME OR PROGRAM NAME   |  |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY   |  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.  |  |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY  |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNED _____  |  |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY  |  |
| 19. RESERVED FOR LOCAL USE  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY   |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)   |  | 20. OUTSIDE LAB? \$ CHARGES<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 1. _____ 3. _____   |  | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.   |  |
| 2. _____ 4. _____   |  | 23. PRIOR AUTHORIZATION NUMBER   |  |
| 24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HPCPS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSTD Family Plan I EMG J COB K RESERVED FOR LOCAL USE  |  |  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>   |  | 26. PATIENT'S ACCOUNT NO.  |  |
| 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.)<br>SIGNED _____ DATE _____   |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  |  | 28. TOTAL CHARGE \$  |  |
| 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #   |  | 29. AMOUNT PAID \$   |  |
|   |  | 30. BALANCE DUE \$   |  |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION