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American Specialty Health Network
P.O. Box 509001
San Diego, CA 92150-9001

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (Include prefix) (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)
5. 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 MM DD YY SEX M ☐ F ☐			b. AUTO ACCIDENT? PLACE (State) ☐YES ☐NO				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			d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER NAME OR BENEFIT PLAN? ☐YES ☐NO

READ BACK OF FORM BEFORE COMPLETING THIS FORM.

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM.

SIGNED _____ DATE _____

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 _____

PHYSICIAN SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐YES ☐NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. ____ . __ 3. ____ . __ 2. ____ . __ 4. ____ . __		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	B PLACE OF SERVICE	C TYPE OF SERVICE	D PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? ☐YES ☐NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS "I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED." SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMBER PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500

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PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to American Specialty Health or designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any health care provider, payor of health claims, or government agency to furnish to American Specialty Health or designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize American Specialty Health or designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by American Specialty Health on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

INSURANCE FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact materials thereto, may be guilty of a criminal act punishable under law and may be subject to civil penalties.