

PLEASE
DO NOT
STAPLE
IN THIS
AREA



HEALTH INSURANCE CLAIM FORM

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED 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) ()		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) 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"/>		b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
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.		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
SIGNED DATE		b. EMPLOYER'S NAME OR SCHOOL NAME	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.	
		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. DATE OF CURRENT ILLNESS (First symptom) OR DATE OF ONSET OF ILLNESS (MM DD YY)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (DATE OF FIRST ONSET) (MM DD YY)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
YOUR PROTECTED HEALTH INFORMATION IS IMPORTANT TO US!				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
Acknowledgement of Review of Notice of Privacy Practices				20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>															
1. I, _____, have reviewed and understand Interactive Counseling & Consulting Services Inc. Notice of Privacy Practices, which explains how my psychological information will be used and disclosed and how I can get access to my psychological information. I know that I may have a copy of the Notice. I also know that from time to time, Interactive Counseling & Consulting Services Inc. may revise the Notice of Privacy Practices. If I want the revised Notice of Privacy Practices, I understand I must ask for it.				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.															
2. _____				23. PRIOR AUTHORIZATION NUMBER															
24. M/				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">DIAGNOSIS CODE</td> <td style="width: 15%;">F \$ CHARGES</td> <td style="width: 10%;">G DAYS OR UNITS</td> <td style="width: 10%;">H EPSDT Family Plan</td> <td style="width: 10%;">I EMG</td> <td style="width: 10%;">J COB</td> <td style="width: 10%;">K RESERVED FOR LOCAL USE</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE							
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Please fill out the pink highlighted boxes if we are filing insurance

HIPAA Patient Consent

I, _____, hereby give consent to Richard V. Zapf, M.S., L.M.F.T. of Interactive Counseling & Consulting Services Inc. and billing agents of Interactive Counseling & Consulting Services Inc. to use/disclose my Protected Health Information for the purpose of Treatment, Payment and Healthcare Operations. I have read the Notice of Privacy Practices provided and understand the way that your office may use or disclose Protected Health Information. I also know that the Notice of Privacy Practices is subject to change, and that I will have access to the changes. I understand that I have a right to request that you limit the use and disclosure of my Protected Health Information for the purpose of Treatment, Payment and Healthcare Operations. I understand that you are not bound by law to grant my request. I understand that I have the right to cancel this consent by informing you, in writing, with the exception of the information that had been disclosed prior to your receipt of my written request to cancel this consent form.

NO. _____

OF FACILITY WHERE SERVICES WERE RECEIVED (an home or office) _____ & PHONE # _____

PIN# _____ GRP# _____