

Medical Claim Form (Continued)

Physician or Supplier Information

Date of illness (first symptom) OR injury (accident) OR pregnancy (LMP)	Date you were first consulted for this condition	If patient has had same or similar injury, give dates	If emergency, check here <input type="checkbox"/>
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Date patient able to return to work	Dates of total disability From _____ Through _____	Dates of partial disability From _____ Through _____
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Name of referring physician or other source (e.g. Public Health Agency)	For services related to hospitalization, give dates Admitted _____ Discharged _____
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Name and address of facility where services were rendered (if other than home or office)	Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Diagnosis or nature of illness or injury 1 _____ 2 _____ 3 _____ 4 _____ Please relate diagnosis to procedures using reference numbers (1,2,3, etc.)	FAMILY PLANNING <input type="checkbox"/> Yes <input type="checkbox"/> No Prior Authorization # (if applicable) <input style="width: 100px; height: 20px;" type="text"/>
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Date of Service	Place of Service	Procedure Code	Fully describe procedures, medical services, or supplies for each date (explain unusual services or circumstances)	Diagnosis Code	Charges	Days or units	TDS	For PacifiCare use only

Patient's Account #	Total Charge	Amt Paid	Balance Due
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Provider's Name	Provider's Address
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Provider's Phone #	Provider's Tax ID #
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21 (IH) Inpatient Hospital	12 (H) Patient's Home	32 (NH) Nursing Home	99 (OL) Other Locations
22 (OH) Outpatient Hospital	52 (PSY) Day Care Facility	31 (SNF) Skilled Nursing Facility	81 (IL) Independent Laboratory
11 (O) Doctor's Office	52 (PSY) Night Care Facility	41 (AMB) Ambulance	99 (OMF) Other Medical Facility

I hereby certify that the services listed above have been performed and payment is therefore due.

Signature of Provider (including degree or credentials)

Date

MAIL COMPLETED FORM TO:

P.O. Box 69312
Harrisburg, PA 17106-9312

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