**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05**

**United Behavioral Health Claims**  
P.O. Box 30755  
Salt Lake City, UT 84130

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Example</th>
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</thead>
</table>
| 1.   | Medicare | Medicare
| 2.   | Patient's Name | Last Name, First Name, Middle Initial |
| 3.   | Patient's Birth Date | MM DD YY |
| 4.   | Insured's Name | Last Name, First Name, Middle Initial |
| 5.   | Patient Relationship to Insured | Self, Spouse, Child, Other |
| 6.   | Insured's Address | (No., Street) |
| 7.   | City | |
| 8.   | State | |
| 9.   | Zip Code | |
| 10.  | Insured's Policy Group or FECA Number | |

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**SIGNED**

11. Date of Current Illness (First symptom or injury) or Infection (Accident or Prenancy/PHI) |

12. Name of Referring Provider or Other Source |

13. Reserved for Local Use |

14. Date of Current Illness (First symptom or injury) or Infection (Accident or Pregnancy/PHI) |

15. If Patient Has Had Same or Similar Illness or Injury (Relate Items 1, 2, 3, 4 or Item 2E by Line) |

16. Date Patient Unable to Work in Current Occupation |

17. Diagnosis or nature of Illness or Injury |

18. Hospitalization Dates Related to Current Services |

19. Outside Lab? $ Charges |

20. Medicaid Resubmission Code |

21. Prior Authorization Number |

22. Reserved for Local Use |

23. Reserved for Local Use |

24. A. Date(s) of Service From To |

25. Federal Tax ID, Number |


27. Accept Assignment? |

28. Total Charge |

29. Amount Paid |

30. Balance Due |

31. Signature of Physician or Supplier |

32. Service Facility Location Information |

33. Billing Provider Info & PH # |

NUCC Instruction Manual available at: www.nucc.org

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