Acclaim
808 Varsity Drive
Tupelo, Mississippi 38801
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Health Insurance Claim Form

PATIENT & INSURED (SUBSCRIBER) INFORMATION

PATIENT'S LAST NAME (First name, Middle Initial)	2. Patient's Date of Birth	3. Insured's Name (First name, middle initial, last name)
4. Patient's Address (Street, city, state, ZIP code & Phone No.)	5. Patient's Sex ❑ Male ❑ Female	6. Insured's I.D. No. or MEDICARE or MEDICAID No. (Include any letters)
	7. Patient's Relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other	8. Insured's Group No. (Or Group Name)
9a. Patient's Other Health Coverage or Insurance: Name & Address of Other Plan or State Assistance:	10. Was condition related to A. Patient's Employment ❑ Yes ❑ No B. An Auto Accident ❑ Yes ❑ No	11. Insured's Address (Street, City, State, ZIP Code)
9b. Name of Employer/Organization Providing Other Coverage:	9c. Policy or Medical Assistance No.	9d. Name of Person insured Under Other Plan

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I authorize release of any medical information necessary to process this claim. If this is a MEDICARE claim, I request payment to myself or to the party who accepts assignment below.

Signed Date

13. I certify that the foregoing statements are true and correct. I do ❑ do not ❑ authorize payment of medical benefits to undersigned physician or supplier for services described below.

Signed (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of	Illness (First symptom) or injury (accident) or pregnancy (LMP)	15. Date first consulted you for this condition	16. Has patient ever had same or similar symptoms? ❑ Yes ❑ No
17. Name of referring physician			18. For services related to hospitalization, give hospitalization dates Admitted: ____/____/____ Discharged: ____/____/____
19. Name & address of facility where services rendered (if other than home or office)			20. Was laboratory work performed outside your office? ❑ Yes ❑ No

21. Diagnosis of nature of illness or injury. Relate diagnosis to procedure in Column D by reference to Numbers 1, 2, 3, etc. or DX code

1.
2.
3.
4.

22. A Date of Service	B. Place of Service	C. Fully describe Procedure, Medical Services or Supplies furnished for each date given — Procedure Code (Identify:)	(Explain unusual services or circumstances)	D Diagnosis Code	E. Charges	F LEAVE BLANK

23. Signature of Physician or Supplier (Read back before signing)	24. Accept assignment (Government claims only) (See back) ❑ Yes ❑ No	25. Total Charges	26. Amount Paid	27. Balance Due
Signed Date	28. Your Social Security No.	29. Physician's or Supplier's Name, Address, Zip Code and Telephone No.		
30. Your patient's Account No.	31. Your Employer I.D. No.	ID No.		