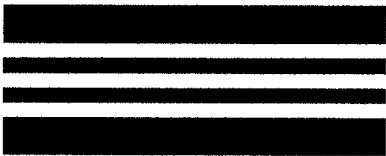


PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** 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)   |  | CITY STATE   |  |
| 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>  |  | ZIP CODE TELEPHONE (INCLUDE AREA CODE)   |  |
| 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? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)   |  |
| 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  |  |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER  |  | a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>  |  |
| b. EMPLOYER'S NAME OR SCHOOL NAME  |  | b. INSURANCE PLAN NAME OR PROGRAM 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.                   |  |

PATIENT AND INSURED INFORMATION

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

|  |   |
|--|---|
| 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. | 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 _____ DATE _____  | SIGNED _____  |

|  |  |  |
|--|--|--|
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM   DD   YY | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY         | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY 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 FROM MM   DD   YY TO MM   DD   YY  |
| 19. RESERVED FOR LOCAL USE   | 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.   |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)      | 23. PRIOR AUTHORIZATION NUMBER   |  |

PHYSICIAN OR SUPPLIER INFORMATION

| A  | B                | C               | D  | E              | F          | G             | H                 | I   | J   | K                      |
|--|------------------|-----------------|--|----------------|------------|---------------|-------------------|-----|-----|------------------------|
| DATE(S) OF SERVICE From MM DD YY To MM DD YY | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | DIAGNOSIS CODE | \$ CHARGES | DAYS OR UNITS | EPSDT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
| 1.   |                  |                 |  |                |            |               |                   |     |     |                        |
| 2.   |                  |                 |  |                |            |               |                   |     |     |                        |
| 3.   |                  |                 |  |                |            |               |                   |     |     |                        |
| 4.   |                  |                 |  |                |            |               |                   |     |     |                        |
| 5.   |                  |                 |  |                |            |               |                   |     |     |                        |
| 6.   |                  |                 |  |                |            |               |                   |     |     |                        |

|  |   |  |  |   |                    |                    |
|--|---|--|--|---|--------------------|--------------------|
| 25. FEDERAL TAX I.D. NUMBER  | SSN EIN <input type="checkbox"/> <input type="checkbox"/> | 26. PATIENT'S ACCOUNT NO.  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> | 28. TOTAL CHARGE \$   | 29. AMOUNT PAID \$ | 30. BALANCE DUE \$ |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) |   | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) |  | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>Robert Goettle</b><br><b>229 Broadway Ave. E, Suite 20 (206) 372-8400</b><br><b>Seattle WA 98102</b> |                    |                    |
| SIGNED _____ DATE _____  |   | PIN# _____ GRP# _____  |  |   |                    |                    |