Physicians Mutual Insurance Company
Claim Services
PO Box 2018
Omaha, NE 68103-2018
Toll-free Number 1.800.228.9100
Omaha Number 1.402.633.1111
Claim Fax Number 1.402.633.1088

Physicians Mutual® Insurance for all of us.®

# Health Insurance Claim Form

**Read instructions before completing or signing this form.**

**Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Type or Print ☐ Medicare ☐ Medicaid ☐ Champus ☐ Auto Injury ☐ Other

## Patient and Insured (Subscriber) Information

| 1. Patient's Name (First, Middle Initial and Last) | 2. Patient's Date of Birth | 3. Insured's Name (First, Middle Initial and Last) |
|---|---|---|
| 4. Patient's Address (Street, City, State and Zip Code) | 5. Patient's Gender ☐ Male ☐ Female | 6. Insured's ID Number or Medicare Number (Include any letters) |
| | 7. Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other | 8. Insured's Group Number or Group Name |
| 9. Other Health Insurance Coverage – Enter Name of Policyowner, Plan Name, and Address and Policy or Medical Assistance Number | 10. Was Condition Related to: A. Patient's Employment? ☐ Yes ☐ No B. An Auto Accident? ☐ Yes ☐ No | 11. Insured's Address (Street, City, State and Zip Code) |
| 12. Patient's or Authorized Person's Signature I Authorize the release of any medical information necessary to process this claim and request payment of Medicare, Champus benefits either to myself or to the party who accepts assignment below. X _____ Date _____ | | 13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described below (Insured or Authorized Person) X _____ |

## 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. Date Patient Able to Return to Work | 18. Dates of Total Disability From _____ Through _____ | Dates of Partial Disability From _____ Through _____ |
| 19. Name and Address of Referring Physician | | 20. For Services Related to Hospitalization Give Hospitalization Dates Admitted _____ Discharged _____ |
| 21. Name and Address of Facility Where Services Rendered (if other than home or office) | | 22. Was Laboratory Work Performed Outside Your Office? ☐ Yes ☐ No Charges: |

23. Diagnosis or 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.

| 24. A. Date of Service | B.* Place of Service | C. Fully Describe Procedures, 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 |
|---|---|---|---|---|---|---|
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| 25. Signature of Physician or Supplier X _____ Date _____ | 26. Accept Assignment (Government Claims Only) ☐ Yes ☐ No | 27. Total Charge | 28. Amount Paid | 29. Balance Due |
|---|---|---|---|---|
| | 30. Your Social Security Number | 31. Physician's or Supplier's Name, Address, Zip Code and Telephone Number | | |
| 32. Your Patient's Account Number | 33. Your Employer ID Number | ID Number | | |

*Place of Service Codes

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 – (IH) | Inpatient Hospital | 4 – (H) | Patient's Home | 7 – (NH) | Nursing Home | O – (OL) | Other Locations |
| 2 – (OH) | Outpatient Hospital | 5 – | Day Care Facility (PSY) | 8 – (SNF) | Skilled Nursing Facility | A – (IL) | Independent Laboratory |
| 3 – (O) | Doctor's Office | 6 – | Night Care Facility (PSY) | 9 – | Ambulance | B – | Other Medical/Surgical Facility |