PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

SECOND FOLD

FIRST FOLD

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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 F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

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.

SIGNED _____ DATE _____

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 _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 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 MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

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.)

SIGNED _____ DATE _____

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 #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB 0938-0008 FORM CMS-1500 (12/90), FORM HHA-1500

CIRCLE ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD:

Appendix	Tonsils	Gall Bladder	Hernia	Heart	Back
Neck	Legs	Colon	Cancer	C-Section	Eyes

Other: _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE BEEN DIAGNOSED WITH:

Appendicitis	Malaria	Chicken Pox	Alcoholism	Scarlet Fever	Tuberculosis
Diabetes	Pneumonia	Diphtheria	Cancer	Arthritis	Fibromyalgia
Whooping Cough	Typhoid Fever	Rheumatic Fever	Heart Disease	Mental Disorder	Venereal Infection
Measles	Mumps	Pleurisy	Small Pox	Polio	Epilepsy
Hepatitis	Anemia	Goiter	Flu	Eczema	Lumbago
Diverticulitis	Acid Reflux	Herpes	AIDS	Bronchitis	

Other: _____

CIRCLE ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

Musculo-skeletal:
Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/Stiffness
Walking Problems
Clicking Jaw/Difficulty Chewing

Nervous System:
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities

General:
Allergies
Loss of Sleep
Fever
Headaches/Migraines
Sore Throat
Ear Aches
Stuffy Nose
Varicose Veins
Ankle Swelling
Lung Problems/Congestion
Chest Pain
Shortness of Breath
Irregular Heartbeat
Heart Problems
Blood Pressure Problems

Gastro-Intestinal:
Poor/Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Trouble
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/Bloating After Meals
Heartburn
Black/Bloody Stool
Colitis

Genito-Urinary:
Bladder Trouble
Painful/Excessive Urination
Discolored Urine

Male/Female:
Menstrual Irregularity
Menstrual Cramping
Vaginal Pain/Infection/Discharge
Breast Pain/Lumps
Prostate/Sexual Dysfunction
Genital Herpes

Other:
Vision Problems
Hearing Difficulties
Dental Problems

DR. DEAN L. FISHMAN
CHIROPRACTIC PHYSICIAN

PLANTATION SPINE & SPORTS REHAB

8267 WEST SUNRISE BOULEVARD PLANTATION, FLORIDA 33322

OFFICE 954 577 6161

ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY AND RELEASE OF INFORMATION

Insurer Please Read the Following, in its Entirety, upon Receipt:

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the ***benefits*** of my No-Fault Policy of automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above medical provider. This assignment of benefits includes over due interest payments and any potential claim for bad faith. I understand it is the express intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the medical provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contact. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider is authorized to appear at any EUO set by the insurer. The medical provider is not the agent of the insurer or the patient.

I understand this assignment will remain in full force and effect and will not be revoked unless the revocation is agreed to by both the medical provider and the undersigned or the undersigned's attorney. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

Power of attorney: The above medical provider is hereby given the power of attorney by the undersigned to sign my name on any checks for payment for services rendered by the above provider.

Release of information: I hereby authorize this medical provider to: furnish the insurer and the patient's attorney with any and all information that may be contained in the medical records; to obtain coverage information telephonically from the insurer; to request all EOBs and non-redacted PIP payout sheets from the insurer; and to obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRIs, from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

I certify that I have not been solicited or promised anything in exchange for receiving medical care or that I have received any promises or guarantees from anyone as to the results that may be obtained by any medical treatment.
Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the terms!

Patient's Name _____

Patient's Signature _____ Date _____
(If patient is a minor, signature of parent/guardian)

Demand is hereby made for a copy of the latest PIP payout sheet and the insurance coverage declaration sheet to be mailed to this provider within 15 days!