### HEALTH INSURANCE CLAIM FORM

**Sample** Marin Behavioral Health and Recovery Services
20 N. San Pedro, Ste. 2025A
San Rafael CA 94913

**Box 31 must be an original signature.**

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA</th>
<th>FECA BALANCE</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Patient Information**

- **Name:**
  - Last Name, First Name, Middle Name
- **Address:**
  - (Number, Street)
- **City:**
- **State:**
- **ZIP Code:**
- **Telephone:** (Include Area Code)

**Insured Information**

- **Social Security or Client Index Number:**
- **Date of Birth:**
- **Sex:**

**Employment Information**

- **Employment:**
  - (Current or Previous)

**Date and Place of Accident**

- **Date:**
- **Place:**
  - (State or City)

**Insured Policy Information**

- **Policy Number:**
- **Issuer:**
- **Insurance Company:**

**Injury/Patient Information**

- **Date of Accident:**
- **Date of Injury:**
- **Place of Accident:**
  - (City, State)

**Additional Claim Information**

- **Diagnosis or Nature of Illness or Injury:**
- **ICD Code:**
- **Current Authorization Number:**
- **Contract Details:**
  - **Contract Rate:**
  - **Amount:**

**Certification**

- **Signature of Person Authorizing Payment:**
- **Date of Signature:**

**NUCC Instruction Manual available at:** www.nucc.org

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### PHYSICIAN OR SUPPLIER INFORMATION

**Your Name and Address:**

- **Name:**
  - (Last Name, First Name, Middle Initial)
- **Address:**
- **Phone Number:**

** NUCC Instruction Manual available at:** www.nucc.org

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### PLEASE PRINT OR TYPE

**Approved OMB-0938-1197 FORM 1500 (02-12)**