DO NOT STAPLE IN THIS AREA

NAME OF INSURANCE _____

ADDRESS: _____ PHONE # (____) _____

APPROVED OMB-0938-0938-0008

PICA ☐ ☐ ☐

HEALTH INSURANCE CLAIM FORM

PICA ☐ ☐ ☐

1. MEDICARE MEDICADE CHAMPUS GROUP FECA OTHER	1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
PATIENT'S NAME (Last name, first name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
PATIENT'S ADDRESS (No. , Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT'S 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, MI)	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 SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH SEX M ☐ F ☐	b. AUTO ACCIDENT? Place (State) ☐ YES ☐ NO
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 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. authorize	

READ BACK OF FORM (OR SECOND PAGE) BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE. I authorize the release of any medical other information necessary to process this claim. I also request payment of government benefites either to myself or the the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Payments of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

Date of current MM DD YY ◀ ILLNESS (first symptom) or INJURY (Accident) OR PREGNANCY (LMP	15. IF PATIENT HAS HAD SAME or sim-ilar illness give first date: MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT From MM DD YY To MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17.a ID 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 ☐ NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate 1,2,3 OR 4 To Item 24C BY LINE)	22. MEDICADE RESUBMISSION CODE / ORIGINAL REFERENCE #
1. _____ 3. _____ 2. _____ 4. _____	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	DIAGNOSIS CODE	E $ CHARGES	F DAYS OR UNITS	G EPSDT FAMILY PLAN	H EMG	I COB	J RESERVED FOR LOCAL USE	K

25. FEDERAL TAX I.D. NUMBER SSN EIN 41-2034960 ☐ X	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO
28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Earl Friesen, M.A., LMFT Signed _____ Date _____	32. NAME AND ADDRESS OF FACILITY WHERE RENDERED (If other than home or office) Life Skills Plus, Inc. 10 Boulder Crescent, Suite 102G Colorado Springs, Colorado 80903 - 719-471-1225	33. PHYSICIAN'S/SUPPLIER'S BILLING NAME, ADDRESS & PHONE # Earl Friesen, M.A., LMFT 10 Boulder Crescent, Suite 102G Colorado Springs, Colorado 80903 - 719-471-1225 PIN# 035540 GRP# LMFT96

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP 1500 FORM RRB 1500