HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA　　　　PICA

CARRIER

1. MEDICARE (Medicare#)　MEDICAID (Medicaid#)　TRICARE (ID#/DoD#)　CHAMPVA (Member ID#)　GROUP HEALTH PLAN (ID#)　FECA BLK LUNG (ID#)　OTHER (ID#)

1a. INSURED'S ID 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT?　YES　NO　PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?　YES　NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?　YES　NO　***If yes,*** complete items 9, 9a, and 9d.

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 undersignd physician or supplier for services described below.

SIGNED ____________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) MM DD YY　QUAL.

15. OTHER DATE　QUAL.　MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.　17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES　FROM MM DD YY　TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?　YES　NO　$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)　ICD Ind.

A. ______　B. ______　C. ______　D. ______

E. ______　F. ______　G. ______　H. ______

I. ______　J. ______　K. ______　L. ______

22. 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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. Rsvd for NUCC Use

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. SERVICE FACILITY LOCATION INFORMATION

a.　b.

33. BILLING PROVIDER INFO & PHONE # ( )

a.　b.

PHYSICIAN OR SUPPLIER INFORMATION

CPAP.com Insurance Claim Instructions

These instructions are provided as a courtesy to customers who have purchased products through CPAP.com and are seeking reimbursement from their insurance company. Our instructions are not a guarantee of payment and we are unable to assist you directly with insurance company claim submissions as avoiding this cost is why we are able to offer you CPAP equipment for such reasonable prices.

Insurance companies typically require the following documentation before paying a claim:

Properly Filled Out Claim Form. Our insurance form is intended as an example and may not be accepted by your insurance company as a legitimate claim form. We suggest you contact your insurance company, determine if they will only accept an official "red" insurance claim form and have them it mail you if needed.
Invoice of Goods Provided. Your CPAP.com invoice is designed to be insurance friendly and will be accepted by nearly all insurance companies.
Prescription or Letter of Medical Necessity. This is a document signed by your physician stating your medical need for CPAP and what CPAP equipment you should receive.
Sleep Study. This document should be the final sleep study presented to your physician for interpretation and prescription.
Letter Explaining Your Insurance Purchase. Your letter should state that you purchased CPAP equipment through CPAP.com and paid out of pocket for the purchase. Therefore they should remit payment to insured. For emphasis, you may consider printing "**Please Pay Insured**" in large, black letters.

Here is advice on properly filling out your claim form:

Box 10. Typically No is the answer to a, b and c.
Box 12. Sign this box.
Box 13. Do not sign this box.
Box 17a. Google "physician UPIN lookup" or visit upin.ecare.com to find this number. It also may be written on your prescription or sleep study.

Box 21. The most frequent diagnosis code for Sleep Apnea is g47.33. However, confirm this with your physician and your copy of the Sleep Study before submitting. Use 780.57 for Central Sleep Apnea.

Here are common mistakes we see:

Not Writing Your Diagnosis Code. You will not be paid until box 21 contains your correct diagnosis code.
Insurance Company Sends CPAP.com A Check. If we receive a check from your insurance company, we will mark it "WE DO NOT ACCEPT ASSIGNMENT, PLEASE PAY INSURED", VOID it and return it to your insurance company. To prevent this, make it abundantly clear to your insurance company that they are to pay you.