PhysMetrics
Formerly Known as ChiroMetrics

MEDICAL CLAIM FORM

PATIENT INFORMATION

1. Patient Name:	2. Patient Date of Birth:	3. Patient ID #:
4. Patient Sex: ☐ Male ☐ Female	5. Patient Phone:	6. Patient Relation to Employee: ☐ Self ☐ Spouse/Domestic Partner ☐ Child ☐ Other
7. Patient Address (Street, City, State, Zip Code): ☐ Check Here if New Address		
8. Insured Name:	9. Insured ID Number:	10. Insured Phone:
11. Insured Address (Street, City, State, Zip Code):		
12. Other Health Insurance Coverage: Is patient covered by any other Health Plan? ☐ Yes ☐ No (If "Yes," complete information below) Name of Other Carrier: _____ Patient Identification #: _____ Name of Insured: _____ Insured Employer: _____ Effective Date of Coverage: _____ Termination Date of Coverage: _____		

13. I authorize the undersigned provider to release any information acquired in the course of my examination or treatment.

Signed (Patient or Patient's Legal Guardian if a Minor) Date

PROVIDER INFORMATION

14. Name & Title of Rendering Provider:	
15. Office Address of Rendering Provider:	16. Office Phone of Rendering Provider:
17. Diagnosis or Nature of Illness or Injury (Relate to Procedure Code in Column D): 1. _____ 3. _____ 2. _____ 4. _____	Place of Service Codes: **11 – Doctor's Office** 72 – Rural Health Clinic 20 – Urgent Care Facility 22 – Outpatient Hospital 21 – Inpatient Hospital 23 – Emergency Room 24 – AMB SURG CTR 31 - Skilled Nursing Facility 32 – Nursing Facility 33 – Custodial Care Facility 41 – Ambulance 51 – INPT PSYCH Facility 52 – PHP PSYCH Facility 53 – Community Mental Health CRT 55 – Substance Abuse RTC 56 – PSYCH RTC 57 – Non-Residential Substance Abuse

18. A-Date of Service: From To	B-Place of Service	C-Description of Medical Services or Supplies Furnished for Each Date Given (CPT Procedure Code)	D-Diagnosis Code	E-Charges	F-Days or Units
19. Your Patient Account Number:		20. Accepts Assignment (Government Claims Only): ☐Yes ☐No		21. Total Charges:	
22. Signature of Provider or Supplier - Including Degree(s) or Credential(s):		23. Tax Identification Number: 24. Taxable Entity Name (If different than Box 25):		25. Provider's, Supplier's, and/or Group Name, Address, Zip Code, & Telephone #:	