

HEALTH INSURANCE CLAIM FORM

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

| | | |
|---|--|---|
| <p>1. INSURANCE TYPE</p> <p><input checked="" type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Group Health Plan <input type="checkbox"/> Other</p> | <p>4. INSURED'S NAME (Last Name, First Name, Middle)</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> | <p>9. INSURED'S POLICY OR GROUP NUMBER</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> |
| <p>2. PATIENT'S NAME (Last Name, First Name, Middle)</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>Not Provided</p> | <p>5. PATIENT'S ADDRESS (No., Street)</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>10030 DITMARS BLVD</p> <p>CITY STATE ZIP</p> <p>ASTORIA NY 11369-</p> | <p>11. INSURED'S DATE OF BIRTH</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>08/02/1940</p> |
| <p>3. PATIENT'S BIRTH DATE</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>08/02/1940</p> | <p>8. PATIENT STATUS</p> <p><input checked="" type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other</p> | <p>17. NAME OF REFERRING PROVIDER</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>Iain Diaev MD</p> <p>17a. NPI</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> |
| <p>7. INSURED'S ADDRESS</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>Street</p> <p>CITY STATE ZIP</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>Not Dr. Not Dr. Not Dr.</p> | <p>10. IS PATIENT'S CONDITION RELATED TO:</p> <p>a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>b. AUTO ACCIDENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>c. OTHER ACCIDENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> | <p>18. HOSPITALIZATION DATES</p> <p>FROM TO</p> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <div style="border: 2px solid red; height: 40px; width: 100%;"></div> <p>02/10/25 Not Provided</p> |

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items A-L to service line below)

| | | | |
|---|---|---|---|
| A | B | C | D |
| E | F | G | H |

24. PROCEDURES, SERVICES, OR SUPPLIES

| Date(s) of Service | Place of Service | Procedures, Services, or Supplies (CPT/HCPCS) | Diagnosis Pointer | Charges | Days/ Units | Rendering Provider NPI |
|--------------------|------------------|---|-------------------|---------|-------------|------------------------|
| Not Done | 11 | | A | 85.00 | 1 | Not Done |
| Not Done | 11 | | R | 45.00 | 1 | Not Done |
| MM/DD | | | | | | |
| | | | | | | |

MM/DD

MM/DD

MM/DD

31. BILLING PROVIDER INFO

NAME

Not Provided

NPI

Not Provided

ADDRESS

Not Provided

CITY

Not Provided

STATE

Not Provided

ZIP

Not Provided

27. ACCEPT ASSIGNMENT

Yes No

28. TOTAL CHARGE

30. BALANCE DUE