|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Health insurance Coverage   |  |  |  |  | | --- | --- | --- | --- | | Medicare | Medicaid | Group plan | Other | |  |  |  |  | | | 2. Patient relationship to insured   |  |  |  |  | | --- | --- | --- | --- | | Self | Spouse | Child | Other | |  |  |  |  | | | | | 3. Insured’s ID Number |
| 4. Patient’s Name  Eglantine Brown | | 5. Patient Birth date  10/10/1997 | | | 6. Insured’s Birth Date | |
| 7. Street Address  1659 Rockford Mountain Lane | | 8. City  Charlotte | | | | 9. State  NJ |
| 10. Zip Code  28203 | | 11. Telephone  9589192191 | | 12. Alternate Telephone | | |
| 13. Is Patient’s Condition Related to:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | a. Employment | | b. Auto Accident | | c. Other Accident | | | Yes | No | Yes | No | Yes | No | | | | | | | |
| 14. Diagnosis or nature of illness or injury   |  |  |  |  | | --- | --- | --- | --- | | a. | b. | c. | d. | | e. | f. | g. | h. | | i. | j. | k. | l. | |  |  |  |  | | | | | | | |
| 15. Claims   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Dates of Service | | | | | | Procedure, service or supplies | | Charges | Amount Paid | |  | FROM | | | TO | | | Description | CPT/HCPCS |  |  | | a. | 01 | 08 | 21 | 03 | 08 | 21 |  |  | 1500 | 0 | | b. |  |  |  |  |  |  |  |  |  |  | | c. |  |  |  |  |  |  |  |  |  |  | | d. |  |  |  |  |  |  |  |  |  |  | | e. |  |  |  |  |  |  |  |  |  |  | | f. |  |  |  |  |  |  |  |  |  |  | | g. |  |  |  |  |  |  |  |  |  |  | | | | | | | |
| 16. Total Charges  1500 | 17. Amount Paid  0 | | 18. Amount Due  1500 | | | |