Save Form | Clear All Fields | Print Only Data | Print Form & Data | Email Form | Email Data Only | PDF SmartForms

1199SEIU BENEFIT FUNDS
330 WEST 42ND STREET
NEW YORK, NY 10036

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#DOD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9013021377

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CLARKE, JOYCE

3. PATIENT'S BIRTH DATE: 02 14 1946 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CLARKE, JOYCE

5. PATIENT'S ADDRESS (No., Street): 108 24 164 PL

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 108 24 164 PL

CITY: JAMAICA | STATE: NY

8. RESERVED FOR NUCC USE

CITY: JAMAICA | STATE: NY

ZIP CODE: 11434 | TELEPHONE (Include Area Code): (555) 555-1212

ZIP CODE: 11563 | TELEPHONE (Include Area Code): (555) 555-1212

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 [X]

a. INSURED'S DATE OF BIRTH: 02 14 1946 | SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

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 [X] *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: SIGNATURE ON FILE | DATE: 04/29/2015

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

SIGNED: SIGNATURE ON FILE

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: MM DD YY FROM — MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN KAUMUDI SOMNAY MD

17a.

17b. NPI: 1568457653

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.: 9

A. 53081 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	START 1052 AM END 1109 AM TOTAL 17 MIN										
1	08 14 14	08 14 14	11		00740	QZ QS P2	A	3500 00	17		NPI	1336195361
2	PROPOFOL 200 MG N400409469930 ME200										
2	08 14 14	08 14 14	11		S0144		A	300 00	20		NPI	1336195361
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 462998043 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 3800 00

29. AMOUNT PAID: $ 0 00

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.)
NIDIA CARRERO MD
SIGNED 04/23/2015 DATE

32. SERVICE FACILITY LOCATION INFORMATION
NORTH CENTRAL MEDICAL OFFICE
200 N CENTRAL AVE
VALLEY STREAM, NY 11580
a. 1568457653 b.

33. BILLING PROVIDER INFO & PH # (555) 555-1212
RADIUS ANESTHESIOLOGY
8560 WEST SUNSET BLVD STE 511
LOS ANGELES, CA 90069
a. 1093154296 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION