1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

Big Company Carrier For Hire - OR
11th Example Rd St Ln #1235
Ocala, FL 34476

CARRIER

PICA

1. MEDICARE [X] (Medicare #) | MEDICAID [ ] (Medicaid #) | TRICARE CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jane Jetson

3. PATIENT'S BIRTH DATE: 07 21 1960 | SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): patient_address

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

7. INSURED'S ADDRESS (No., Street): insured_address

CITY: Ocala | STATE: FL

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Ocala | STATE: FL

ZIP CODE: 34476 | TELEPHONE (Include Area Code): (352) 555-5555

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 34476 | TELEPHONE (Include Area Code): (352) 555-5555

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial): Flinstone, Frederick, C

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 12341251

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123451

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 11 04 47 | SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: 10 31 55 | SEX: M [X] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME: University of Central London

c. EMPLOYER'S NAME OR SCHOOL NAME: University Of Florida

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Bad Wolf

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

SECOND FOLD

PATIENT AND INSURED INFORMATION

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: 2012-08-02

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 02 03 12

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: 02 10 12

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 02 10 12 TO 02 11 12

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Other Source or Provider

17a. J1 10000000000002

17b. NPI 12031021230

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 02 10 12 TO 02 14 12

19. RESERVED FOR LOCAL USE: Reserved for future use

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 999999 01

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. V722 83
2. 720 2
3. 100 2
4. 100 2

22. MEDICAID RESUBMISSION CODE: MRC-1 | ORIGINAL REF. NO.: probably unused

23. PRIOR AUTHORIZATION NUMBER: 100000000020310

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

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: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	7232750177382
	03 29 95	09 12	05	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	7863999534753
2	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	2895994763025
	03 21 84	10 10	84	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	618849184217
3	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	4223111406578
	07 04 79	06 26	78	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	7520802968474
4	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	4874097662776
	11 11 02	11 11	83	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	777451707518
5	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	6615243309768
	06 08 06	09 06	99	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	8780749486310
6	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	8622951724274
	05 26 71	06 08	85	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	9145206640555

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

26. PATIENT'S ACCOUNT NO.: 999999999999999

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

28. TOTAL CHARGE: $ 200 01

29. AMOUNT PAID: $ 201 99

30. BALANCE DUE: $ 201 99

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.)

Physician Signature

SIGNED | DATE: 2012-01-02

32. SERVICE FACILITY LOCATION INFORMATION

Service or Facility Name - OR
12345 Example Rd
Miami FL 34476

a. 10000000000 b. 10000000000

33. BILLING PROVIDER INFO & PH. #: (555) 555-5555

North Shore ANES Partners
12345 Example Rd
Miami 34476 FL

a. 10000000000 b. 10000000000

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS