1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

BIG COMPANY CARRIER FOR HIRE - OR
11th EXAMPLE RD ST LN #1235
PLACEMENT
OCALA, FL 34476

CARRIER

PICA

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: PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: RESERVED FOR LOCAL

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

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

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	8182476763759
	11 19 77	09 12	98	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	8132432715095
2	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	8064792325324
	10 18 11	01 04	05	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	3963349106430
3	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	6574387476388
	04 12 08	04 19	81	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	1691529311166
4	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	2401883649350
	07 06 94	04 29	80	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	6025209282810
5	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	1971325033649
	03 01 02	11 07	00	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	3251621826322
6	START: 8:20AM END: 9:12AM MINUTES: 52 (Whatever you want!)									J1	4428550160150
	01 09 08	09 28	06	22	12	00851	10 10 10 10	1	200	01	20	Y	NPI	876563471384

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: $ -1 | 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: 2012-01-02 DATE

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

NUCC Instruction Manual available at: www.nucc.org

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

WCMS-1500CS