Health Insurance Claim Form

BLUE CROSS
PO BOX 60007
LOS ANGELES, CA 90060-0007

PICA	MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER
☐	☐	☐	☐	☐	☐	☐	☒	XBP852398283

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
SMITH, AUSTIN	04 20 1995	☒ M ☐ F	SMITH, AMY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)	5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
SMITH, AMY	15467 W CANTERBURY DR	☐ Self ☒ Spouse ☐ Child ☐ Other

CITY	STATE	ZIP CODE	TELEPHONE (Include Area Code)	7. INSURED'S ADDRESS (No., Street)
SURPRISE	AZ	85379	623 910-1750	

8. RESERVED FOR NUCC USE	CITY	STATE	ZIP CODE	TELEPHONE (Include Area Code)

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
		041075
9a. OTHER INSURED'S POLICY OR GROUP NUMBER	10a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	11a. INSURED'S DATE OF BIRTH
9b. RESERVED FOR NUCC USE	10b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	11b. OTHER CLAIM ID (Designated by NUCC)
9c. RESERVED FOR NUCC USE	10c. OTHER ACCIDENT? ☐ YES ☒ NO	11c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS
9d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
	SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI
JACLYN BOWDEN		1508411190

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
G4733

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS POINTER	F. CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID #
11 25 24	11		95800	A	750.00	1		ZZ	207Q5120X
								NPI	1154410967

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?
262616649	☐ SSN ☒ EIN	C502439720	☒ YES ☐ NO

28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
$ 750.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCATION INFORMATION
SIGNATURE ON FILE	HARAMANDEEP SINGH MD INC 5201 NORRIS CANYON RD, STE SAN RAMON, CA 94583-5410
33. BILLING PROVIDER INFO & PH #	NPI
HARAMANDEEP SINGH MD 5201 NORRIS CANYON RD STE 120 SAN RAMON, CA 94583-5410	1316105802