

HEALTH INSURANCE CLAIM FORM

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

MD MEDICARE PART B
Novitas Solutions
Mechanicsburg
PA 17055

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1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 5GD9K96FF15																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cohen, Brenda												3. PATIENT'S BIRTH DATE MM DD YY 12 30 53 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>												4. INSURED'S NAME (Last Name, First Name, Middle Initial) Cohen, Brenda																																															
5. PATIENT'S ADDRESS (No., Street) 8502 WACO DR												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED'S ADDRESS (No., Street) 8502 WACO DR																																															
CITY FORT WASHINGTON												STATE MD												CITY FORT WASHINGTON												STATE MD																																			
ZIP CODE 207440												TELEPHONE (Include Area Code) (301) 248-7725												ZIP CODE 20744												TELEPHONE (Include Area Code) (301) 248-7725																																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												11. INSURED'S POLICY GROUP OR FECA NUMBER																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. INSURED'S DATE OF BIRTH MM DD YY 12 30 53 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>												b. OTHER CLAIM ID (Designated by NUCC)																																															
b. RESERVED FOR NUCC USE												c. INSURANCE PLAN NAME OR PROGRAM NAME MD MEDICARE PART B												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																																															
c. RESERVED FOR NUCC USE												10d. CLAIM CODES (Designated by NUCC)												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME												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 06/04/2024												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. ILLNESS												15. OTHER DATE MM DD YY QUAL. ILLNESS												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Canuella SERWAH Akrofi NP												17a. NPI 17b. NPI 1548872385												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 04 20 2023 TO																																															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO												22. RESUBMISSION CODE ORIGINAL REF. NO.																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. G93 40 B. J15 212 C. J96 11 D. A41 9 E. R00 0 F. M24 521 G. M24 541 H. E11 9 I. Z43 0 J. K. L.												23. PRIOR AUTHORIZATION NUMBER												24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE EMG C. 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 08 22 2023 08 22 2023 32 1 99309 ABCDEF 145 00 1 NPI 1548872385																																																																							
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4																																																																							
5																																																																							
6																																																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN 83-3973422 <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. 67721-748369												27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 145 00												29. AMOUNT PAID \$ 79 56												30. Rsvd for NUCC Use 65 44											
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.) Canuella SERWAH Akrofi NP 06/04/24 SIGNED DATE												32. SERVICE FACILITY LOCATION INFORMATION Fairland Center 2101 Fairland Rd Silver Spring, MD, 209045427 a. NPI b.												33. BILLING PROVIDER INFO & PH # (224) 236-4600 COMPREHENSIVE REHAB CONSULTANTS PLLC 415 W. GOLF ROAD ARLINGTON HEIGHTS, IL, 600053923 a. 1710529771 b.																																															