MD DC MEDICARE PART B
PO Box 3399
Attn: Part B claims
Mechanicsburg
PA 17055

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 7UV7J74MY34

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bowers-Dobbins, Nellie

3. PATIENT'S BIRTH DATE MM DD YY: 01 30 52 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bowers-Dobbins, Nellie

5. PATIENT'S ADDRESS (No., Street): 716 CAPITOL SQUARE PLACE SW

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

7. INSURED'S ADDRESS (No., Street): 716 CAPITOL SQUARE PLACE SW

CITY: WASHINGTON STATE: DC

8. RESERVED FOR NUCC USE

CITY: WASHINGTON STATE: DC

ZIP CODE: 200240 TELEPHONE (Include Area Code): ( )

ZIP CODE: 20024 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Bowers-Dobbins, Nellie

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 MM DD YY: 01 30 52 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 [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MD DC MEDICARE PART B

d. INSURANCE PLAN NAME OR PROGRAM NAME: MD BCBS CAREFIRST

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *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: 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 QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Canuella SERWAH Akrofi NP

17a.

17b. NPI: 1548872385

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 03 27 2024 TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. M17 0 B. Z86 73 C. I69 354 D. M62 81
E. M62 81 F. R26 9 G. Z74 1 H. M17 0
I. Z86 73 J. I69 354 K. M62 81 L. M62 81

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	04	12 2024	04	12	2024	11		20550		ABCDEF	114 00	1		NPI	1548872385
2	04	12 2024	04	12	2024	31	1	99309		ABCDEF	145 00	1		NPI	1548872385
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 83-3973422

26. PATIENT'S ACCOUNT NO.: 191213-1155282

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

28. TOTAL CHARGE: $ 259 00

29. AMOUNT PAID: $ 43 71

30. Rsvd for NUCC Use: 215 29

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

SIGNED 06/04/24 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Doctors Community Rehabilitation and P
6710 Mallery Dr
Lanham, MD, 207063964

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.

NUCC Instruction Manual available at: www.nucc.org