HEALTH INSURANCE CLAIM FORM

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

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PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[X] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [ ] (ID#)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Salemy, Cheryl A	3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 66 SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street) 500 West Summit Hill Drive	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]
CITY Knoxville	STATE TN
ZIP CODE 37902	TELEPHONE (Include Area Code) (877) 355-4141
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Salemy, Susan J	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER OtherPolicy12345678	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. RESERVED FOR NUCC USE 9b reserved for NUCC Use	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO TN
c. RESERVED FOR NUCC USE 9c reserved for NUCC Use	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME 9d Ins Plan Name or Program Name	10d. CLAIM CODES (Designated by NUCC) 10d Claim codes
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 02 DD 10 YY 17 QUAL 123456	15. OTHER DATE QUAL QL MM 02 DD 21 YY 17
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE xx Smith, Jane MD	17a. 17a 21-02215464 17b. NPI 25-1987531
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) additional claim information	20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES 1000.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. E A. a525.10 B. b525.00 C. c525.10 D. d545.54 E. e522.20 F. f524.22 G. g454.20 H. h545.56 I. i541.22 J. j542.21 K. k654.10 L. l585.56	22. RESUBMISSION CODE ABC123 ORIGINAL REF. NO. origrefno123456 23. PRIOR AUTHORIZATION NUMBER priorauth123465

	1. FROM MM	DD	YY	TO MM	DD	YY	2. PLACE OF SERVICE	3. EMG	4. CPT/HCPCS	5. MODIFIER				6. DIAGNOSIS POINTER	7. $ CHARGES	8. DAYS OR UNITS	9. EPSDT Family Plan	10. ID. QUAL	11. RENDERING PROVIDER ID. #
1	02	10	17	02	10	17	21	1C	99201	01	02	03	04	1	125.00	1	H	NPI	25-1987555
2	C 02	10	17	02	10	17	A33	2C	11400	21	22	23	24	2	100.00	2	H	NPI	25-1234567
3	02	si	17	02	10	17	44	3C	640	31	32	33	34	3	10.50	1	3	NPI	25-2121212
4	02	11	17	02	11	17	44	4C	99444	41	42	43	44	4	40.40	4	H	NPI	25-4141414
5	02	11	17	02	12	17	55	5C	11451	51	52	53	54	5	55.00	5	H	NPI	25-5454542
6	02	12	17	02	13	17	66	6C	11478	61	62	63	64	6	66.00	6	H	NPI	25-6565656

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
47-1234567	[ ] [X]	AC-549879	[X] YES [ ] NO	$ 396.90	$ 200.00	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (800) 111-2222
31 signture of physician SIGNED 02/28/2017 DATE	Facility name 112 Facility Road Newtown, SC 88765 a. 32-216649a b. 32-245165b	Facility name Billing Provider Info 33 Billing Provider Street Billingstown NC 66554 a. 33-216649a b. 33-245165b

PHYSICIAN OR SUPPLIER 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 12 signiture here DATE 02/28/17

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 13 signiture here