1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

BLUE CROSS AND BLUE SHIELD OF MN
914 43RD STREET
SUITE W-201
ST PAUL, MN 00123-0098

CARRIER

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X987-1234A-032

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): THOMPSON, ANNE MARIE, H

3. PATIENT'S BIRTH DATE MM DD YY: 12 12 1958 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): THOMPSON, ROBERT, H

5. PATIENT'S ADDRESS (No., Street): 5813 CRADLE ROCK COURT

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

7. INSURED'S ADDRESS (No., Street): 5813 CRADLE ROCK COURT

CITY: ST PAUL STATE: MN

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: ST PAUL STATE: MN

ZIP CODE: 00123-0054 TELEPHONE (Include Area Code): (001) 5551212

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 00123-0054 TELEPHONE (Include Area Code): (510) 5551212

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): THOMPSON SR, ROBERT, G

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: BSBS54321

a. OTHER INSURED'S POLICY OR GROUP NUMBER: X0987654321

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 18 1956 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 12 12 1918 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MN

b. EMPLOYER'S NAME OR SCHOOL NAME: PRICE WATERHOUSE COOPERS

c. EMPLOYER'S NAME OR SCHOOL NAME: US ARMY (RETIRED)

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS BLUE SHIELD PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME: MAMSI SENIOR PREFERRED PPO

10d. RESERVED FOR LOCAL USE: CLAIM ATTACHMENT

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *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: SOF DATE: 07/01/2007

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: SOF

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY: 07 01 2007 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 07 01 2007

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 07 01 2007 TO 07 20 2007

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: ROBERT SMITH MD

17a. 1B 987654321

17b. NPI 0005678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 07 01 2007 TO 07 02 2007

19. RESERVED FOR LOCAL USE: 1234567890A

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 150050

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. E885.0
2. E234
3. E901
4. 903.5490

22. MEDICAID RESUBMISSION CODE: 12345678955 ORIGINAL REF. NO.: ABC1234567890

23. PRIOR AUTHORIZATION NUMBER: 123456789123456789123456789555

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. #
7BEGIN 1245 END 1425 TIME 90 MINUTES													N	1B	12345678901
07	01	07	07	05	07	22	N	00770	25 26 LT RT	134	875 00	6	Y	NPI	012345789
7BEGIN 1245 END 1415													N	1D	12345678901
07	01	07	07	01	07	22	Y	00770	P2 P2 P2 P2	134	875 00	90	N	NPI	0123456789
ZZKAYE WALKER													N	1B	12345678901
07	01	07	07	01	07	12	N	E1399	25 26 26 28	12	165 50	1	N	NPI	0123456789
N400026064871 IMMUNE GLOBULIN INTRAVENOUS UN2													AV	1B	12345678901
07	01	07	07	01	07	11	N	J1563	RT LT 28 29	13	500 00	20	N	NPI	0123456789
VPA122BIC5D6E7G													NU	1B	12345678901
07	01	07	07	02	07	11	N	A6410		13	15 00	2	N	NPI	0123456789
OZ00301134678906													N	1B	12345678901
07	01	08	07	07	07	11	Y	A6410	25 26 RT LT	1 3	500 00	2	N	NPI	0123456789

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 555666777888

26. PATIENT'S ACCOUNT NO.: 20070613235249

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

28. TOTAL CHARGE: $ 2930 50

29. AMOUNT PAID: $ 30 49

30. BALANCE DUE: $ 2900 01

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.)

SOF SIGNED 12/12/2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION
LABCORP DIAGNOSTOC
123 HEALTHCARE LANE
ST PAUL MN 00342-1111
a. 0123456789 b. 1B123456789

33. BILLING PROVIDER INFO & PH # (012) 5551212
THE PEDIATRICS GROUP
1234 MAIN STREET
COLUMBIA MN 00123-0765
a. 0123456789 b. 1B987654321

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