1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

Humana
PO Box 14610
Lexington KY 40512-4610

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 890456732

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, John

3. PATIENT'S BIRTH DATE MM DD YY: 06 15 1955 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, John

5. PATIENT'S ADDRESS (No., Street): 1234 Main Street

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

7. INSURED'S ADDRESS (No., Street): 1234 Main Street

CITY: Anywhere STATE: CA

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

CITY: Anywhere STATE: CA

ZIP CODE: 90210 TELEPHONE (Include Area Code): (987)654-3210

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

ZIP CODE: 90210 TELEPHONE (Include Area Code): (987)654-3210

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: AN905-678

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: 06 15 1955 SEX M [X] F [ ]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME: Universal Studios

c. EMPLOYER'S NAME OR SCHOOL NAME:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Humana

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] 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: Signature On File DATE: 01 21 2011

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

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: Op rpt attached

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 250 00 | 0 00

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

1. 525.25
2. 785.6
3.
4.

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

23. PRIOR AUTHORIZATION NUMBER: 567890456

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 JO01 02 21 11	02 21 11	11		21248		1	6000 00	3		NPI	8934267812
2 02 21 11	02 21 11	11		21210	99 51 52	1	3000 00	1		NPI	8934267812
3 ZZInterim prosthesis JO01 02 21 11	02 21 11	11		21089		1	1200 00	1		NPI	8934267812
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 364246789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE: $ 10200 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 10200 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.)
Olya Zahrebelny DDS
SIGNED
02 21 2011
DATE

32. SERVICE FACILITY LOCATION INFORMATION
Dr. Olya Zahrebelny
636 North Michigan Avenue 3500
Chicago, IL 60610
a. 8934267812 b.

33. BILLING PROVIDER INFO & PH #: (312) 657 3400
Dr. Olya Zahrebelny
636 North Michigan Avenue 3500
Chicago, IL 60610
a. 8934267812 b.

NUCC Instruction Manual available at: www.nucc.org

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