HEALTH INSURANCE CLAIM FORM

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

PICA PICA

1. MEDICARE ☐ (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) 12/13/2018
2.PATIENT'S NAME(Last Name, First Name, Middel Initial) Patient Name	3.PATIENT'S BIRTH DATE MM | DD | YY 07 09 1971 SEX M ☐ F ☑	4.INSURED'S NAME (Last Name, First Name, Middle Initial) Patient Name
5.PATIENT'S ADDRESS(No., Street) 1102 ELIZABETH	6.PATIENT'S RELATIONSHIP TO INSURED Self ☑ Spouse ☐ Child ☐ Other ☐	7.INSURED'S ADDRESS(No., Street) 1102 ELIZABETH
CITY ROSENBERG STATE TX	8.RESERVED FOR NUCC USE	CITY ROSENBERG STATE TX
ZIP CODE 77471 TELEPHONE (Include Area Code) (832) 449-9479		ZIP CODE 77471 TELEPHONE (Include Area Code) ( )
9.OTHER INSURED'S NAME(Last Name, First Name, Middel Initial)	10.IS PATIENT'S CONDITION RELATED TO:	11.INSURED'S POLICY GROUP OR FECA NUMBER
a.OTHER INSURED'S POLICY OR GROUP NUMBER	a.EMPLOYEMENT? (Current or Previous) ☐ YES ☑ NO	a.INSURED'S DATE OF BIRTH MM | DD | YY 07 09 1971 SEX M ☐ F ☑
b.RESERVED FOR NUCC USE	b.AUTO ACCIDENT? ☑ YES ☐ NO PLACE(State) |____|	b.OTHER CLAIM ID (Designated by NUCC)
c.RESERVED FOR NUCC USE	c. OTHER ACCIDENT ☐ YES ☑ NO	c.INSURANCE PLAN NAME OR PROGRAM NAME
d.INSURANCE PLAN NAME OR PROGRAM NAME	10d.CLAIM CODES(Designated by NUCC)	d.IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☑ No *If yes,* complete items 9,9a,and 9d.
READ BACK FORM COMPLETING & SIGNING THIS FORM. 12.PATIENTS 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 30 2019		13.INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undesigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE
14.DATE OF CURRENT ILLNESS,INJURY, or PREGNANCY (LMP) MM | DD | YY 12 13 2018 QUAL.| 431	15.OTHER DATE QUAL.| | 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 DN SMITH, CORNELL	17a 17b NPI 1821210162	18.HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM To MM | DD | YY
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.| 0 | A. | M7582 B. | M129 C. | M7542 D. | M25512 E. | M5020 F. | G9529 G. | M4802 H. | G548 I. | J. | K. | L. |		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 01	30	2019	01	30	2019	49		73221	LT				ABCD	4000	00	1		NPI 1518997824
2 01	30	2019	01	30	2019	49		72141					EFGH	4000	00	1		NPI 1518997824
3																		NPI
4																		NPI
5																		NPI
6																		NPI

25.FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☑ 452499238	26.PATIENT'S ACCOUNT NO SUTL79723	27.ACCEPT ASSIGNMENT? (For govt, claims, see back) ☑ YES ☐ NO	28.TOTAL CHARGE $ 8000 | 00 29.AMOUNT PAID $ 0 | 00 30.Rsvd for NUCC Use $ |
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGRESS OR CblackENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) GOMBERAWALLA, MUS 01 30 2019 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION SUGAR LAND 19875 SOUTHWEST FREEWAY, SUITE SUGARLAND TX 77479 a. 1184902249 b.	33. BILLING PROVIDER INFO & PH # (281) 545-2226 ELITE HEALTH SERVICES - SUGAR 19875 SOUTHWEST FREEWAY. SUITE SUGAR LAND TX 77479 a. 1184902249 b.	