HEALTH INSURANCE CLAIM FORM

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

PICA

MEDICAREJI
PO BOX 1051

AUGUSTA, GA 30903-1051

CARRIER

PICA

1. MEDICARE (Medicare#) [X] 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): 2GR8VR9EC53

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Misailegaly, Kereti

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1975 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 216 E 15th St #b

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

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

CITY: Long Beach STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 90813 TELEPHONE (Include Area Code): (562) 3509354

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 95287103C

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

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

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 [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAID

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: 01 21 2025

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.

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

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): CLAIM 2 OF 2;CHARGE EXCEEDS LINE TOTAL

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. E11621 B. L97512 C. D. E. F. G. H. 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 01212025	01212025	11		Q4303	76 JZ	AB	48454 00	14		NPI	1043265549
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]: 954525202 X

26. PATIENT'S ACCOUNT NO.: 146655 21903 X

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

28. TOTAL CHARGE $: 48454 00

29. AMOUNT PAID $: 0 00

30. Rsvd for NUCC Use

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.)
RAYMOND BAUTISTA DPM
SIGNATURE ON FILE DATE: 01 23 2025

32. SERVICE FACILITY LOCATION INFORMATION
KIM FOOT AND ANKLE CENTER
701 E 28TH STREET STE 111
LONG BEACH CA 908062715
a. 1467471326 b.

33. BILLING PROVIDER INFO & PH # (562) 4262551
KIM FOOT AND ANKLE CENTER INC
701 E 28TH STREET SUITE 111
LONG BEACH CA 908062715
a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

ENVELOPE BSS-02508-024

FIRST FOLD

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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