HEALTH INSURANCE CLAIM FORM

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

FL MEDICARE PART B FIRST COAST
PO BOX 44117

JACKSONVILLE FL 322314117

CARRIER

XXX PICA

PICA XXX

1. MEDICARE X (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): 5PR1HH2DW20

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MORALES, HENRIETTA

3. PATIENT'S BIRTH DATE MM DD YY: 12 12 1933 — SEX: M ( ) F (X)

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

5. PATIENT'S ADDRESS (No., Street): 3817 RIVER GROVE CT

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

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

CITY: TAMPA — STATE: FL

8. RESERVED FOR NUCC USE

CITY: — STATE:

ZIP CODE: 336101649 — TELEPHONE (Include Area Code): ( )

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

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: NONE

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 — 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

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *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:

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 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 — MM DD YY TO:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN IMEE M DOWNING

17a. 1G

17b. NPI 1750970885

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ESANO ACA 4X6,24 SQUARE CM, INVOICE PRICE $63648

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. L89323 B. K5904 C. I10 D. Z7401
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

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 22 25	01 22 25	12		99349	25	A	442 00	1		G2	993402374
										NPI	1750970885
2 01 22 25	01 22 25	12		15271		A	532 00	1		G2	993402374
										NPI	1750970885
3 01 22 25	01 22 25	12		97605	59	A	146 00	1		G2	993402374
										NPI	1750970885
4 01 22 25	01 22 25	12		Q4275		A	63648 00	24		G2	993402374
										NPI	1750970885
5 01 22 25	01 22 25	12		A6550		A	400 00	1		G2	993402374
										NPI	1750970885
6 01 22 25	01 22 25	12		A7000		A	400 00	1		G2	993402374
										NPI	1750970885

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 993402374

26. PATIENT'S ACCOUNT NO.: 44

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

28. TOTAL CHARGE: $ 65568 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.)
IMEE M DOWNING, SIGNED 01 31 25 DATE

32. SERVICE FACILITY LOCATION INFORMATION
3817 RIVER GROVE CT
TAMPA FL 336101649
a. 1457192650 b.

33. BILLING PROVIDER INFO & PH # (813) 6003559
Oasis Care Clinic Inc
13107 BEE BLOSSOM PL
RIVERVIEW FL 335794080
a. 1457192650 b. G2 993402374

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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 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

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26. PATIENT'S ACCOUNT NO.: 44

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

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29. AMOUNT PAID: $ 0 00

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