HEALTH INSURANCE CLAIM FORM

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

BCBSMI: MEDICARE PLUS BLUE (MEDICARE REPL
PO BOX 32593

DETROIT, MI 482320593

CARRIER

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PATIENT AND INSURED INFORMATION

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): XYL991641818

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CARSKADON RICKIE L

3. PATIENT'S BIRTH DATE: 08 07 1955 — SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1456 GALLERY PLACE DR

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

7. INSURED'S ADDRESS (No., Street): 1456 GALLERY PLACE DR

CITY: JACKSON — STATE: MI

8. RESERVED FOR NUCC USE

CITY: JACKSON — STATE: MI

ZIP CODE: 492017051 — TELEPHONE (Include Area Code): (517) 4949596

ZIP CODE: 492017051 — TELEPHONE (Include Area Code): (517) 4949596

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: 37051

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 08 07 1955 — SEX: M [X] 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: BCBSMI: MEDICARE PLUS BLUE (ME

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 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: 02 10 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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 04 2025 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

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)

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. L97522 C. L97821 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 02 04 25	02 04 25	12		15275		AB	500 00	1		NPI	1386775419
2 02 04 25	02 04 25	12		Q4275	JZ	AB	11200 00	4		NPI	1386775419
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 933772290 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 2523V30652

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

28. TOTAL CHARGE: $ 11700 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 11700 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.)
JAMIE G. TAWEEL, DO
SIGNED 02 10 2025 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ADVANCED WOUND CARE OF CARO PC
1800 WEST CARO RD
CARO MI 487238829
a. 1700666708 b.

33. BILLING PROVIDER INFO & PH # ( )
ADVANCED WOUND CARE OF CARO PC
PO BOX 37697
BELFAST ME 049151218
a. 1700666708 b.

NUCC Instruction Manual available at: www.nucc.org — ***PLEASE PRINT OR TYPE*** — APPROVED OMB-0938-1197 FORM 1500 (02-12)

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