HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Salemy, Cheryl A

3. PATIENT'S BIRTH DATE: 10 | 16 | 66 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 500 West Summit Hill Drive

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

7. INSURED'S ADDRESS (No., Street): 500 West Summit Hill Drive

CITY: Knoxville STATE: TN

8. RESERVED FOR NUCC USE: field 8 reserved for NUCC use

CITY: Knoxville STATE: TN

ZIP CODE: 37902 TELEPHONE (Include Area Code): (877) 355-4141

ZIP CODE: 37902 TELEPHONE (Include Area Code): (877) 355-4141

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Policy123456678

a. OTHER INSURED'S POLICY OR GROUP NUMBER: OtherPolicy12345678

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

a. INSURED'S DATE OF BIRTH: 10 | 16 | 66 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE: 9b reserved for NUCC Use

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

b. OTHER CLAIM ID (Designated by NUCC): xx | 11b Other claim ID

c. RESERVED FOR NUCC USE: 9c reserved for NUCC Use

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: 11c Insurance Plan Name

d. INSURANCE PLAN NAME OR PROGRAM NAME: 9d Ins Plan Name or Program Name

10d. CLAIM CODES (Designated by NUCC): 10d Claim codes

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: 12 signiture here DATE: 02/28/17

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: 13 signiture here

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 | 10 | 17 QUAL: 123456

15. OTHER DATE QUAL: QL 02 | 21 | 17

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 02 | 10 | 17 TO 02 | 22 | 17

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: xx | Smith, Jane MD

17a. 17a 21-02215464

17b. NPI 25-1987531

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 02 | 11 | 17 TO 02 | 21 | 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): additional claim information

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 1000.00

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

A. a525.10 B. b525.00 C. c525.10 D. d545.54

E. e522.20 F. f524.22 G. g454.20 H. h545.56

I. i541.22 J. j542.21 K. k654.10 L. l585.56

22. RESUBMISSION CODE: ABC123 ORIGINAL REF. NO.: origrefno123456

23. PRIOR AUTHORIZATION NUMBER: priorauth123465

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 10 17	02 10 17	21	1C	99201	01 02 03 04	1	125.00	1	H	NPI	25-1987555
2	C 02 10 17	02 10 17	A33	2C	11400	21 22 23 24	2	100.00	2	H	NPI	25-1234567
3	02 si 17	02 10 17	44	3C	640	31 32 33 34	3	10.50	1	3	NPI	25-2121212
4	02 11 17	02 11 17	44	4C	99444	41 42 43 44	4	40.40	4	H	NPI	25-4141414
5	02 11 17	02 12 17	55	5C	11451	51 52 53 54	5	55.00	5	H	NPI	25-5454542
6	02 12 17	02 13 17	66	6C	11478	61 62 63 64	6	66.00	6	H	NPI	25-6565656

25. FEDERAL TAX I.D. NUMBER: 47-1234567 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: AC-549879

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

28. TOTAL CHARGE: $ 396.90

29. AMOUNT PAID: $ 200.00

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.)

31 signture of physician

SIGNED 02/28/2017 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Facility name
112 Facility Road
Newtown, SC 88765

a. 32-216649a b. 32-245165b

33. BILLING PROVIDER INFO & PH # (800) 111-2222

Facility name Billing Provider Info
33 Billing Provider Street
Billingstown NC 66554

a. 33-216649a b. 33-245165b