

HEALTH INSURANCE CLAIM FORM

Attny. Bobby Saadian 3055 Wilshire Blvd. 12th Floor Los Angeles, CA 90010

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

PICA	50,02.12	PICA						
1. MEDICARE MEDICAID TRICARE	HEALTH PLAN RIKILING	1a. INSURED'S I.D. NUMBER (For Program in Item 1)						
(Medicare#) (Medicaid#) (ID#/DoD#)	(Member ID#) (ID#) X (ID#)	•						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX 08 21 1973 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
RAMIREZ CARABAY (P.I), RAUL 5. PATIENT'S ADDRESS (No., Street)	08 21 1973 M X F	RAMIREZ CARABAY (P.I), RAUL						
Second Section Control of the Contro		7. INSURED'S ADDRESS (No., Street)						
242 HEMMINGWAY CT.	Self X Spouse Child Other STATE 8. RESERVED FOR NUCC USE	242 HEMMINGWAY CT.						
TULARE	CA CA	TULARE CA						
ZIP CODE TELEPHONE (Include Area Co		ZIP CODE TELEPHONE (Include Area Code)						
93274 (559) 9915025		93274 (559) 9915025						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Ini	nitial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX						
	YES X NO	08 21 1973 MX F						
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)						
	X YES NO							
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME						
	YES X NO	Attny. Bobby Saadian						
d. INSURANCE PLAN NAME OR PROGRAM NAME	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 COI 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I aut	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize							
to process this claim. I also request payment of government beneath	payment of medical benefits to the undersigned physician or supplier for services described below.							
below.	11 /07 /0010	OTONATUDE ON ETTE						
SIGNATURE ON FILE	DATE 11/07/2018	SIGNATURE ON FILE						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LI	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY							
QUAL.	QUAL.	FROM TO						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY						
40 ADDITIONAL OLANA INFORMATION (Device de la MILION)	FROM TO 20. OUTSIDE LAB? \$ CHARGES							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		77						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	A-I to service line below (24E)							
M79.7M47.812	A-L to service line below (24E) ICD Ind. 0 M5 4 . 1 6	22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. 11734	B. M47.012 C. M47.010 D. M34.10							
E. L	G. L H. L	23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE B. C. D	D. PROCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.						
From To PLACE OF MM DD YY SERVICE EMG	(Explain Unusual Circumstances) DIAGNOSIS CPT/HCPCS MODIFIER POINTER							
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	ATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use						
	P23975A1 X YES NO	\$ 2115 00 \$ 0 00						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	33. BILLING PROVIDER INFO & PH # (661) 3279300							
(I certify that the statements on the reverse CV)	J R Grandhe MD A Medical							
106	6401 Truxtun Ave Suite B							
11/28/2018	LARE, CA 932742344	Bakersfield, CA 933090674						
SIGNED DATE a. 10	003058637	1003058637						



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