

HEALTH INSURANCE CLAIM FORM

2002年 日66日		HEALTHFIRST, INC (NEW YORK) - HCFA ONLY	1		
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HEALTH INSURANCE CLAIM FORM	PO BOX 958438 LAKE MARY, FL 32795				
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	/12		ن ا		
1. MEDICARE MEDICAID TRICARE CH	MPVA GROUP FECA OTHER	PICA	<u> </u>		
	MPVA GROUP HEALTH PLAN BLK LUNG X (ID#) (ID#) GROUP (ID#) FECA OTHER (ID#) (ID#)	112912891			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
AHMED, FAUZIA	AHMED, FAUZIA				
5. PATIENT'S ADDRESS (No., Street)	7. INSURED'S ADDRESS (No., Street)				
37-44 64TH STREET	Self X Spouse Child Other TE 8. RESERVED FOR NUCC USE	37-44 64TH STREET	<u> </u>		
WOODSIDE		WOODSIDE	2		
ZIP CODE TELEPHONE (Include Area Code		ZIP CODE TELEPHONE (Include Area Code)	⊢ [₹		
11377		11377	٥		
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			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY M F Y	NOTITEM TO SHE THE SHE THE SHE SHE SHE SHE SHE SHE SHE SHE SHE S		
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	01 03 1940 F X b. OTHER CLAIM ID (Designated by NUCC)			
	YES X NO				
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME			
	YES X NO		_		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
READ BACK OF FORM BEFORE COMP	TING & SIGNING THIS FORM	YES X NO If yes, complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize	41		
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE author to process this claim. I also request payment of government benefits below.	the release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED SIGNATURE ON FILE	DATE 09/17/2018	SIGNATURE ON FILE	_\		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO TO TO	1		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY				
	FROM TO TO				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES				
ADDITIONAL CLAIM INFORMATION 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	convice line below (24E)	YES X NO			
	. M70.662 M70654	22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. <u>M17.0</u> B. <u>M79.661</u> F. <u>—</u>	D. <u>M79.662</u> B. L. H. L. H. L.	23. PRIOR AUTHORIZATION NUMBER	\dashv		
F	a				
	OCEDURES, SERVICES, OR SUPPLIES Explain Unusual Circumstances) EXPLAIN DIAGNOSIS	F. G. H. I. J. DAYS EPSDIT ID. RENDERING OR Family QUAL. PROVIDER ID. #	$\exists i$		
	HCPCS MODIFIER POINTER	\$ CHARGES UNITS Plan QUAL. PROVIDER ID. #	_		
00 47 40 00 47 40 4	10	00 101 107 10707			
09 17 18 09 17 18 11 9	10 12345	60 UN NPI 1659515823			
09 17 18 09 17 18 11 9	40 59 12345	60 UN NPI 1659515823			
	12040	1000010020			
09 17 18 09 17 18 11 9	32 12345	60 UN NPI 1659515823			
		, , , , , , , , , , , , , , , , , , , ,			
09 17 18 09 17 18 11 9	12 59 12345	60 UN NPI 1659515823			
00 47 40 00 47 40 10	05	NO NO NO			
09 17 18 09 17 18 11 9	35 12345	60 UN NPI 1659515823			
		NPI NPI	- 6		
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIE	T'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd.for NUCC U	Jse		
461964102 X	\$ 300				
INCLUDING DEGREES OR CREDENTIALS	E FACILITY LOCATION INFORMATION EHABILITATION PT, PC	33. BILLING PROVIDER INFO & PH # (
(I certify that the statements on the reverse BEL	BEL REHABILITATION PT PC				
WOODS NY 44077		88-29 180TH STREET 2ND FLR JAMAICA, NY 11432			
LOPEZ, BASILIO, MD WOO	SIDE, NY 11377	JAMAICA, NY 11432			



HEALTH INSURANCE CLAIM FORM

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

HEALTHFIRST, INC (NEW YORK) - HCFA ONLY

-CARRIER -

PO BOX 958438 LAKE MARY, FL 32795

PICA						PICA
1. MEDICARE MEDICAID	TRICARE CHAMPV	A GROUP	FECA OTHER	1a. INSURED'S I.D. NUMBER		(For Program in Item 1)
(Medicare#) (Medicaid#)	(ID#/DoD#) (Member II	D#) HEALTH PLAN [(ID#) X (ID#)	112912891		
2. PATIENT'S NAME (Last Name,	First Name, Middle Initial)	3. PATIENT'S BIRTH DA		4. INSURED'S NAME (Last Name	e, First Name,	Middle Initial)
AHMED, FAUZIA		I i i	14 - 17	AHMED, FAUZIA		
5. PATIENT'S ADDRESS (No., Str	eet)	01 03 194	, 	7. INSURED'S ADDRESS (No., Street)		
` ' '				, i i		
37-44 64TH STREET	low-re-	Self X Spouse	Child Other	37-44 64TH STREET		1
CITY	STATE	8. RESERVED FOR NU	CC USE	CITY		STATE
WOODSIDE	NY			WOODSIDE		NY
ZIP CODE TELEPHONE (Include Area Code)				ZIP CODE TELEPHONE (Include Area Code		E (Include Area Code)
11377	()			11377		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY (1)					OR FECA NU	JMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH		SEX
W. STREET HOOFIED OF GEIGT OFF GROOF HOWBETT		YES	X NO	MM DD YY	М	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	IX NO	01 03 1940		<u> </u>
b. HEGERVED FOR WOOD GOE			PLACE (State)	b. OTHER CLAIM ID (Designate	d by NUCC)	
		YES	X NO			
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR	PROGRAM N	NAME
		YES	X NO			
d. INSURANCE PLAN NAME OR	PROGRAM NAME	10d. CLAIM CODES (De	esignated by NUCC)	d. IS THERE ANOTHER HEALTH	H BENEFIT PL	AN?
				YES X NO	<i>If yes</i> , comple	te items 9, 9a, and 9d.
	BACK OF FORM BEFORE COMPLETING			13. INSURED'S OR AUTHORIZE		
	PERSON'S SIGNATURE I authorize the uest payment of government benefits either			payment of medical benefits to	o the undersig	ned physician or supplier for
below.	est payment of government benefits either	to mysell of to the party wi	io accepts assignment	services described below.		
SIGNED SIGNATUR	E ON FILE	09/3	27/2018	SIGNATU	RE ON FIL	F
OIGITED		BATE	172010	SIGNED		
14. DATE OF CURRENT ILLNESS MM DD YY	' , ' ' , ' , ' , ' , ' , ' , ' , ' , '	OTHER DATE MM	DD YY	16. DATES PATIENT UNABLE T		
	JAL. QU	AL.		FROM	ТО	
17. NAME OF REFERRING PROV	/IDER OR OTHER SOURCE 17a	ι.		18. HOSPITALIZATION DATES F		CURRENT SERVICES MM , DD , YY
17b. NPI FROM TO						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? \$ CHARGES			
ADDITIONAL CLA	M INFORMATION			YES X NO		
	ILLNESS OR INJURY Relate A-L to serv	ice line below (24E)	DD Ind.	22. RESUBMISSION CODE		
▲ I M17.0	M79.661	M79.662	M70651	CODE	ORIGINAL R	EF. NO.
M70050	B	1017 9.002	D. 1017 903 1	23. PRIOR AUTHORIZATION NU	IMRER	
E. <u>M79652</u>	F. L G. L		н	20. THIOTIAGTHONIZATION	JWDEI I	
I	J K		L		T T .	
24. A. DATE(S) OF SERVICE		EDURES, SERVICES, OR ain Unusual Circumstances		F. G. DAYS OR	H. I. EPSDT Family ID.	J. RENDERING
MM DD YY MM D			·	\$ CHARGES UNITS	Plan QUAL.	PROVIDER ID. #
09 27 18 09 2	27 18 11 97110		12345	60 UN	NPI	1659515823
09 27 18 09 2	27 18 11 97140	59	12345	60 UN	NPI	1659515823
., , , , , , , ,	, 10 11 17 17	, 55	12010			111111111111111111111111111111111111111
09 27 18 09 2	27 18 11 97032		12345	60 UN	NPI	1659515823
00 21 10 00 2	. 10 11 97032		12343	OU ON		1000010020
00 07 10 00	7 40 44 5-5-				1	4050545000
09 27 18 09 2	27 18 11 97035		12345	60 UN	NPI	1659515823
	The state of the s	1 1 1	1 1	1 1 1		
					NPI	
	1 1 1	1		1 1	,	
					NPI	
25. FEDERAL TAX I.D. NUMBER	SSN EIN 26. PATIENT'S A	ACCOUNT NO. 27.	ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29	. AMOUNT PA	30. Rsvd.for NUCC Use
461964102 X YES X NO \$ 240 \$						
31. SIGNATURE OF PHYSICIAN	31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO &	PH# (
INCLUDING DEGREES OR CREDENTIALS					(/
and the above held and an arrange and the supple		ABILITATION PT, PC H STREET		BEL REHABILITATION PT PC 88-29 180TH STREET 2ND FLR		
33-30 0411 3 TREET				88-29 1801H STREET 2ND FLR JAMAICA, NY 11432		
LOPEZ, BASILIO, MD WOODSIDE, NY 11377			·			
SIGNED 10/03/2018	a. 1194063	2209 b. 46		a. 1194062209 b.		