Test Company

1500
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLKLUNG OTHER ( ) (Medicare #) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (Member ID#) ( ) (SSN or ID) ( ) (SSN) (X) (ID)		1a. INSURED'S I D. NUMBER (For Program in Item 1) 0000
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, John	3. PATIENT'S BIRTH DATE SEX MM DD YY 01 26 1990 M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, John
5. PATIENT'S ADDRESS (No., Street) 1234 Test St	6. PATIENT RELATIONSHIP TO INSURED Self (X) Spouse ( ) Child ( ) Other ( )	7. INSURED'S ADDRESS (No., Street) 1234 Test St
CITY San Francisco STATE CA	8. PATIENT STATUS Single (X) Married ( ) Other ( ) Employed ( ) Full-Time Student ( ) Part-Time Student ( )	CITY San Francisco STATE CA
ZIP CODE 94414 TELEPHONE (Include Area Code) (888) 123 4567		ZIP CODE 94414 TELEPHONE (Include Area Code) (888) 123 4567
9. OTHER INSURED'S NAME (Last, First, 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) ( ) YES (X) NO	a. INSURED'S DATE OF BIRTH SEX MM DD YY 01 26 1990 M (X) F ( )
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M ( ) F ( )	b. AUTO ACCIDENT? (X) YES ( ) NO PLACE(State) CA	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ( ) YES (X) NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES (X) NO If yes, return to add complete item 9 a-d.
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 06/10/2022		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
14. DATE OF CURRENT: ILLNESS(First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 06 20 21	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES ( ) YES (X) NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate tems 1, 2, 3 or 4 to Item 24E by Line) 1. F431 3. 2. 4.		22. MEDICAID 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												
2	06 10 22	06 10 22	2		NOSHO	95	1	100.00	1		NPI	0123456789
3											NPI	
4											NPI	
5											NPI	
6											NPI	
											NPI	

25. FEDERAL TAX I D. NUMBER SSN EIN 222222222 ( ) (X)	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES ( ) NO	28. TOTAL CHARGE $100.00	29. AMOUNT PAID $	30. BALANCE DUE $100.00
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.) Doe, Jane SIGNED 12/15/2022 DATE	32. SERVICE FACILITY LOCATION NFORMATION Jane Doe, MD 1234 Test Ave San Francisco, CA 94414 a. 0123456789 b.	33. BILLING PROVIDER INFO & PH# (111) 222 3333 Jane Doe, MD 1234 Test Ave San Francisco, CA 94414 a. 1234567890 b.			