1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MODA
39103
11015 HELICOPTER
PORTLAND, OR 97202

CARRIER

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1231

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KLOWN, KRUSTY

3. PATIENT'S BIRTH DATE MM DD YY: 05 13 2010 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KLOWN, KRUSTY

5. PATIENT'S ADDRESS (No., Street): 123 MAIN STREET

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

7. INSURED'S ADDRESS (No., Street): 123 MAIN STREET

CITY: PORTLAND STATE: OR

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: PORTLAND STATE: OR

ZIP CODE: 97202 TELEPHONE (Include Area Code): (503) 234-1120

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 97202 TELEPHONE (Include Area Code):

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: 12412

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 05 13 2010 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: MODA

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and 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: 02/28/2014

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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: BOOM BOOM, MD

17a.

17b. NPI 102023432

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 249.00 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 | 08 16 2013 | | 08 16 2013 | | | 11 | | 86308 | | 1 | 0 00 | 1 | | NPI | 1023005410 |
| 2 | 08 16 2013 | | 08 16 2013 | | | 11 | | 81002 | | 1 | 0 00 | 1 | | NPI | 1023005410 |
| 3 | 08 16 2013 | | 08 16 2013 | | | 11 | | 17000 | | 1 | 0 00 | 1 | | NPI | 1023005410 |
| 4 | | | | | | | | | | | 0 00 | | | NPI | |
| 5 | | | | | | | | | | | 0 00 | | | NPI | |
| 6 | | | | | | | | | | | 0 00 | | | NPI | |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO.: 1

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

28. TOTAL CHARGE $ 0 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 0 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.)

MICHAEL CHEN, MD 02/28/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

TEST CLINIC
3835 SE CENTER ST.
PORTLAND, OR 97202

a. 1030320203 b.

33. BILLING PROVIDER INFO & PH # (503) 234-1120

MICHAEL CHEN, MD
3835 SE CENTER ST.
PORTLAND, OR 97202

a. 1030320203 b.

NUCC Instruction Manual available at: www.nucc.org

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