Medical Claim Form

Patient Information:

- **Name:** John Doe
- **Date of Birth:** 02/12/1980
- **Address:** 123 Main St, Anytown, CA 12345
- **Phone:** 555-555-5555
- **Policy Number:** ABC12345

Provider Information:

- **Name:** Jane Smith, MD
- **Address:** 456 Elm St, Anytown, CA 12345
- **NPI:** 9876543210
- **Tax ID:** 12-3456789

Claim Information:

- **Date of Service:** 08/15/2024
- **Type of Service:** Office Visit
- **CPT Code:** 99213
- **ICD-10 Code:** M25.511 (Osteoarthritis, right knee)
- **Charges:** $200.00
- **Amount Paid:** $0.00

Procedure Information:

- **Procedure Code:** 20610 (Arthrocentesis, aspiration and/or injection, major joint)
- **Procedure Description:** Knee injection for osteoarthritis
- **Date of Procedure:** 08/15/2024

Diagnostics Information:

- **X-ray:** Right knee, 2 views (CPT: 73562)
- **MRI:** Right knee, without contrast (CPT: 73721)

- **Lab Test:** Complete Blood Count (CPT: 85025)

Authorization:

- **I hereby authorize** the release of any medical information necessary to process this claim.
- **Signature:** _____
- **Date:** _____

Additional Information:

- **Referring Physician:** Dr. John Smith
- **Pre-existing Conditions:** Hypertension, Diabetes

Please note that this is a sample form and actual forms may vary based on specific insurance requirements and regulations.