HEALTH INSURANCE CLAIM FORM

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

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CARRIER

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 4444553

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 27 1956 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 45 Doe Road

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

7. INSURED'S ADDRESS (No., Street): 45 Doe Street

CITY: Chicken Road | STATE: AZ

8. RESERVED FOR NUCC USE

CITY: DOE | STATE: NJ

ZIP CODE: 45963 | TELEPHONE (Include Area Code): (452) 5949594

ZIP CODE: 95826 | TELEPHONE (Include Area Code): (654) 5558475

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Insurance Company

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: GHHF844

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY: 05 21 1990 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): dfa9994953

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Yellow

d. INSURANCE PLAN NAME OR PROGRAM NAME: Bronze

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 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 fjfjjfa DATE 02/23/2023

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 ahamdmmd

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 03 11 2024 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: ghhhgjf

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	01	03	12	01	4	23			PRF	H g tf gk	fd	1234.34	3	2	NPI fjjjfj564
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 0.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION