

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

200 SANDY SPRINGS PL  
ATLANTA, GA 30328-5917

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) MVA04062025									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REPTA, DANIEL										3. PATIENT'S BIRTH DATE 10081976 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) REPTA, DANIEL										5. PATIENT'S ADDRESS (No., Street) 3338 HILL POND DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 3338 HILL POND DR									
CITY Buford										STATE GA									
ZIP CODE 30519										TELEPHONE (Include Area Code) ( )									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>										CITY Buford									
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										STATE GA									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										14. INSURED'S DATE OF BIRTH 10081976 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
15. EMPLOYER'S NAME OR SCHOOL NAME										16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
17. INSURANCE PLAN NAME OR PROGRAM NAME										18. EMPLOYER'S NAME OR SCHOOL NAME									
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27. RESERVED FOR LOCAL USE										28. RESERVED FOR LOCAL USE									
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97. RESERVED FOR LOCAL USE										98. RESERVED FOR LOCAL USE									
99. RESERVED FOR LOCAL USE										100. RESERVED FOR LOCAL USE									



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b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
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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 09172025										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 FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE BARBARA PERSAUD										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. M54.2 3. M54.59 2. M54.6 4. M25.561										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 07222025 07222025 11 99214 1234 1750.00 1 NPI 1831186857										2 NPI										3 NPI																			
4 NPI										5 NPI										6 NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 883646709 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 254383A										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1750.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 1750.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true. All other statements are true hereof.) BARBARA MCMILLAN PERSAUD SIGNED 09172025 DATE										32. SERVICE FACILITY LOCATION INFORMATION ATLAS SPINE AND REHAB INC 5855 JIMMY CARTER BLVD SUITE NORCROSS, GA 30071-2984										33. BILLING PROVIDER INFO & PH # 6786915651 BARBARA MCMILLAN-PERSAUD 5855 JIMMY CARTER BLVD STE 210 NORCROSS, GA 30071-2984 a. 1831186857 b.																			



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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. G44.319 3. M25.562 2. M25.561 4. M54.16										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. #																																																	
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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																											
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25. FEDERAL TAX I.D. NUMBER SSN EIN 883646709 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 264614A										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1470.00										29. AMOUNT PAID \$ 0.00										30. BALANCE DUE \$ 1470.00									
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a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY 10081976 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																	
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c. EMPLOYER'S NAME OR SCHOOL NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.										12. PATIENT'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 DATE 09172025																																																	
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 FROM MM DD YY TO MM DD YY																																																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE BARBARA PERSAUD										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. M54.2 3. M54.59 2. M54.6 4. M25.561										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 09052025 09052025 10 99213 1234 1470.00 1 NPI 1831186857										2										3																																																	
3										4										5																																																	
4										5										6																																																	
5										6										6																																																	
6										6										6																																																	
25. FEDERAL TAX I.D. NUMBER 883646709										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 266202A										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1470.00										29. AMOUNT PAID \$ 0.00										30. BALANCE DUE \$ 1470.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and correct to the best of my knowledge and belief.) BARBARA MCMILLAN PERSAUD SIGNED DATE 09172025										32. SERVICE FACILITY LOCATION INFORMATION ATLAS SPINE AND REHAB INC 5855 JIMMY CARTER BLVD SUITE NORCROSS, GA 30071-2984										33. BILLING PROVIDER INFO & PH # 6786915651 BARBARA MCMILLAN-PERSAUD 5855 JIMMY CARTER BLVD STE 210 NORCROSS, GA 30071-2984																																																	



1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

200 SANDY SPRINGS PL  
ATLANTA, GA 30328-5917

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) MVA04062025																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REPTA, DANIEL										3. PATIENT'S BIRTH DATE MM DD YY 10081976 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) REPTA, DANIEL																			
5. PATIENT'S ADDRESS (No., Street) 3338 HILL POND DR										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 3338 HILL POND DR																			
CITY Buford										STATE GA										CITY Buford										STATE GA									
ZIP CODE 30519										TELEPHONE (Include Area Code) ( )										ZIP CODE 30519										TELEPHONE (Include Area Code) ( )									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY 10081976 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.										12. PATIENT'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 DATE 09172025																			
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 FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE BARBARA PERSAUD										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. M54.2 3. M54.59 2. M54.6 4. M25.561										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 09102025 09102025 11 99214 1234 1750.00 1 NPI 1831186857										2 NPI										3 NPI																			
4 NPI										5 NPI										6 NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 883646709 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 271240A										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1750.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 1750.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and correct to the best of my knowledge and belief.) BARBARA MCMILLAN PERSAUD SIGNED 09172025 DATE										32. SERVICE FACILITY LOCATION INFORMATION ATLAS SPINE AND REHAB INC 5855 JIMMY CARTER BLVD SUITE NORCROSS, GA 30071-2984										33. BILLING PROVIDER INFO & PH # 6786915651 BARBARA MCMILLAN-PERSAUD 5855 JIMMY CARTER BLVD STE 210 NORCROSS, GA 30071-2984																			