HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) (ID#) (ID#)	HRH698C78933
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flemming, Sarah	3. PATIENT'S BIRTH DATE: 07 01 1981 SEX: M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Flemming, Sarah	
5. PATIENT'S ADDRESS (No., Street): 33 Woods Hill Road	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child X Other
7. INSURED'S ADDRESS (No., Street): 33 Woods Hill Road	
CITY: Foxborough STATE: MA	8. RESERVED FOR NUCC USE
CITY: Foxborough STATE: MA	
ZIP CODE: 02035 TELEPHONE (Include Area Code): (508) 623-2299	
ZIP CODE: 02035 TELEPHONE (Include Area Code): (508) 623-2299	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Flemming, Rachel	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 174176M1B0	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: HRH111C00LO9	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH: 07 01 1981 SEX: M F X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield	
d. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield	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: Sarah Flemming DATE: 06/05/2015

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:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 06 01 15 QUAL:	15. OTHER DATE QUAL: 05 02 15
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 06 01 15 TO 06 10 15	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Terry, Mary L.	17a. 17b. NPI 1590898990
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 06 01 15 TO 06 10 15	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES X NO $ CHARGES: 156.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. A. R51 B. I10 C. D. E. F. G. H. I. J. K. L.	22. 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 06 01 15	06 10 15	11		99214	25	123	156 00	10		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 943300697 SSN EIN: X	26. PATIENT'S ACCOUNT NO.: 8904	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE: $ 156.00	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.): Jennifer Kraft 06/11/15 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Beth Israel Hospital, 123 Longwood Avenue, Boston, MA 02139; a. 1770629412 b.		33. BILLING PROVIDER INFO & PH #: (617) 618-9981 Beth Israel Hospital 123 Longwood Avenue Boston, MA 02139 a. 1770629412 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)