HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): LMS000M47OP3

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gray, Samuel III

3. PATIENT'S BIRTH DATE: 10 23 78 SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Gray, Samuel III

5. PATIENT'S ADDRESS (No., Street): 600 Northpoint Pkwy

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): 600 Northpoint Pkwy

CITY: West Palm Beach STATE:

8. RESERVED FOR NUCC USE

CITY: West Palm Beach STATE: FL

ZIP CODE: 30303 TELEPHONE (Include Area Code): (561) 640-9172

ZIP CODE: 30303 TELEPHONE (Include Area Code): (561) 640-91721

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 383838M9N3

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 383835J0L2

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

a. INSURED'S DATE OF BIRTH: 10 23 78 SEX: M (X) F ( )

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 ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem Blue Cross Blue Shield

d. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem 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 _____ DATE _____

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 1 15 16 QUAL.

15. OTHER DATE QUAL. MM DD YY: 1 27 16

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Janet Hues

17a.

17b. NPI 7871342756

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

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

A. 345.87 B. 583.03 C. 540.98 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	1 15	17	1 27	17	33	Y	100786	11		345.87	50 31			NPI	9006772983
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 890785768 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 50 31

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.)

Connor Sheen 2/2/17

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

JFK Medical Center
2201 45th St
West Palm Beach, FL 33407

a. 7871342756 b.

33. BILLING PROVIDER INFO & PH # (561) 274-8567

JFK Medical Center
2201 45th St
West Palm Beach, FL 33407

a. 7871342756 b.