HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (08/05)

PICA

1. MEDICARE (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: LMLD00A36NL2

2. PATIENT'S NAME (Last, First, Middle Initial): Frasier, William, I.

3. PATIENT'S BIRTH DATE: 08 31 57 SEX: X

4. INSURED'S NAME (Last, First, Middle Initial): Frasier, William, I.

5. PATIENT'S ADDRESS (No., Street): 111 Hollywood Blvd

6. PATIENT RELATIONSHIP TO INSURED: X Self

7. INSURED'S ADDRESS (No., Street): 111 Hollywood Blvd

CITY: Los Angeles STATE: CA

ZIP CODE: 90027 TELEPHONE (Include Area Code): (213) 974-3211

ZIP CODE: 90027 TELEPHONE: (213) 974-3211

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Frasier, Robin, M.

10. IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT? YES X NO AUTO ACCIDENT? YES X NO PLACE (State) OTHER ACCIDENT? YES X NO

11. INSURED'S POLICY GROUP OR FECA NUMBER: 776892N8B3

11a. INSURED'S DATE OF BIRTH: 08 31 57 SEX: M X F

11b. EMPLOYER'S NAME OR SCHOOL NAME:

11c. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem Blue Cross

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO (If yes, complete items 9, 9a, and 9d.)

9a. OTHER INSURED'S POLICY OR GROUP NUMBER: LMLD00A69NM1

9b. OTHER INSURED'S DATE OF BIRTH: SEX: M F

9c. EMPLOYER'S NAME OR SCHOOL NAME:

9d. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem Blue Cross

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:

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 11 15 16 QUAL.

15. OTHER DATE: QUAL. 11 01 16

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 11 15 16 TO 12 22 16

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Mark Schlumberg

17a. 17b. NPI 8681342735

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 11 15 16 TO 12 22 16

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? X YES NO $ CHARGES: 33 60

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

A. 389.01 B. L15 C. 689.22 D. 671.45

E. 341.22 F. 322.98 G. 300.11 H. L10

22. RESUBMISSION CODE: 2134 ORIGINAL REF. NO.: 45990393

23. PRIOR AUTHORIZATION NUMBER: 459302111

	24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	24B. PLACE OF SERVICE	24C. EMG	24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. $ CHARGES	24G. DAYS OR UNITS	24H. EPSDT Fam. Plan	24I. ID. QUAL.	24J. RENDERING PROVIDER ID. #
1	11 15 16	11 20 16	25	Y	100124	31	389.01	132 00	6		NPI	1245994810
2	11 21 16	11 29 16	25		100458	27	L15	233 80	9		NPI	4532678934
3	11 30 16	12 1 16	25		27386	43	689.22	71 33	2		NPI	4532678934
4	12 2 16	12 17 16	71	Y	35768	33 41 78	341.22	856 79	16		NPI	6745838283
5	12 18 16	12 20 16	71		37521		300.11	156 00	2		NPI	6743219033
6	12 21 16	12 22 16	71		37789	12 11 10 37	322.98	129 68	2		NPI	6743218399

25. FEDERAL TAX I.D. NUMBER: 890411657 SSN X EIN

26. PATIENT'S ACCOUNT NO.: 5238 X

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

28. TOTAL CHARGE: $ 1604.20

29. AMOUNT PAID: $ 123.71

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.): Jonathan Hall, 12/23/16

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: UCLA Medical Center, 757 Westwood Plaza, Los Angeles, CA90095

a. 6743218399 b.

33. BILLING PROVIDER INFO & PH #: (310) 825-9111

UCLA Medical Center, 757 Westwood Plaza, Los Angeles, CA90095

a. 6743218399 b.

NUCC approved and Mandated for Electronic Filing

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Clear Form

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION