HEALTH INSURANCE CLAIM FORM

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

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 (For Program in Item 1): LML000A36NL2

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

3. PATIENT'S BIRTH DATE MM 08 DD 31 YY 57 SEX M ☒ F ☐

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

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

CITY: Los Angeles STATE: CA

8. RESERVED FOR NUCC USE

CITY: Los Angeles STATE: CA

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: LML000A69NM1

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM 08 DD 31 YY 57 SEX M ☒ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

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

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

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 11 DD 15 YY 16 QUAL.

15. OTHER DATE QUAL. MM 11 DD 01 YY 16

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY 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 MM DD YY FROM 11 15 16 TO 12 22 16

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☒ NO ☐ $ CHARGES 3360

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

A. 389.01 B. L15 C. L689.22 D. 671.45
E. 341.22 F. 322.98 G. 300.11 H. L10
I. J. K. L.

22. RESUBMISSION CODE 2134 ORIGINAL REF. NO. 45990393

23. PRIOR AUTHORIZATION NUMBER 459302111

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 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	37322.98	129.68	2		NPI	6743218399

25. FEDERAL TAX I.D. NUMBER 890411657 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO. 5238

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 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 SIGNED 12/23/16 DATE

32. SERVICE FACILITY LOCATION INFORMATION

UCLA Medical Center
757 Westwood Plaza
Los Angeles, CA 90095

a. 6743218399 b.

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

UCLA Medical Center
757 Westwood Plaza
Los Angeles, CA 90095

a. NPI 6743218399 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Clear Form