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#) [X] | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): HRH698C78933

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flemming, Sarah

3. PATIENT'S BIRTH DATE MM DD YY: 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 [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 07 01 1981 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] 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: 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 [ ] NO [X] *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) MM DD YY: 06 01 15 QUAL

15. OTHER DATE QUAL MM DD YY: 05 02 15

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: 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 MM DD YY: 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 SSN EIN: 943300697 [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

SIGNED 06/11/15 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Beth Israel Hospital
123 Longwood Avenue
Boston, MA 01239

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)