# 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 [X] (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 DD YY: 08 31 57 SEX M [X] 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 [X] 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 [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 08 31 57 SEX M [X] F [ ]

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: 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 [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 _____ 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 DD YY: 11 15 16 QUAL.

15. OTHER DATE QUAL. MM DD YY: 11 01 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 [X] 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 | 322.98 | 129.68 | 2 | | NPI | 6743218399 |

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

26. PATIENT'S ACCOUNT NO.: 5238

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] 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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Clear Form

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION