HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

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): 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: 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
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 37	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. 6743218399 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Clear Form