PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
11-2234-10190

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John	M X / F	Doe, Jane
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse X / Child / Other	7. INSURED'S ADDRESS (No., Street)
123 Any Street		123 Any Street
CITY: Any City / STATE: CA	8. PATIENT STATUS: Single / Married X / Other; Employed / Full-Time Student / Part-Time Student	CITY: Any City / STATE: CA
ZIP CODE: 92127 / TELEPHONE (Include Area Code): (858) 555-0100		ZIP CODE: 92127 / TELEPHONE (INCLUDE AREA CODE): (858) 555-0100
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: G4683A
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY: 06 12 65 / SEX M / F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES / X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Group Insur of Amer.
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO *If yes*, return to and complete item 9 a-d.

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: Jdoe DATE: 01-15-2021

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: JaneDoe

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
10 11 21	10 11 21	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
Self		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. R11.0 3. R19.7		23. PRIOR AUTHORIZATION NUMBER
2. K59.00 4. K92.1		

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 11 21	11		90801		170.00					1234567890
2 10 11 21	11		90805		140.00					1234567890
3 10 11 21	11		90812		93.00					1234567890
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
555-88-9999 X		X YES / NO	$ 405.00	$	$

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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
MtJackson 10/11/21 SIGNED DATE	Mateo Jackson PhD 9876 Healthcare Ave Any Town, CA 92126	Mateo Jackson PhD 9876 Healthcare Ave (920) 555-0101 Any Town, CA 92126 PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Group Insurance of America | Community Plan

Health Plan (80840) 911-87726-04

Member ID: 11-2234-10190 Group Number: AAAAA

Member:

JOHN DOE

PCP Name: **MATEO JACKSON, PhD**

PCP Phone: **(920)-555-0101**

Payer ID: 87726

InsurRX

Rx Bin: 610494
Rx Grp: AAAAA
Rx PCN: 00000

0501

Administered by Amer. Insurance Community Plan, Inc.

MEDICAID PLAN OF XXXX

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or visit www.capitalone.com/nohasslerewards

ACCOUNT SUMMARY FOR PERIOD DECEMBER 22, 2015 - JANUARY 25, 2016

Rewards Checking 00008986028085

Previous Balance 12/21/15	$757.29
7 Deposits/Credits	$10,011.98
53 Checks/Debits	-$8,427.95
Service Charges	$0.00
Ending Balance 01/25/16	$2,341.32

Number of Days in Cycle	35
Minimum Balance This Cycle	$757.29
Average Collected Balance	$2,419.68

Rewards Summary

Previous Balance	7600
Earned This Period	0
Transferred In This Period	0
Transferred Out This Period	0
Redeemed This Period	0
Adjustments This Period	0
Ending Balance	7600

ACCOUNT DETAIL FOR PERIOD DECEMBER 22, 2015 - JANUARY 25, 2016

Rewards Checking 00008986028085

Date	*Amount*	*Resulting Balance*	*Transaction Type*	*Description*	*Debit Card*
12/22	$5,000.00	$5,757.29	Deposit	Customer Deposit	
12/22	-$500.00	$5,257.29	Debit	ATM withdrawal ATM WITHDRAWAL 00E141 122115 470 PARK AVE SOUTH NEW YORK NY	
12/22	-$23.98	$5,233.31	Debit	Debit Card Purchase KEY FOOD #1458 614588 122115 KEY FOOD #1458 BRONX NY	4168


UNITED STATES
DRIVER LICENSE
EXPIRES 09/21/2034
DL 6383736743891101
CLASS C
END NONE
LN DOE
FN JOHN
123 ANY STREET
ANY CITY, CA 92127
DOB 09/21/1970
SSN ON FILE
DONOR
SEX M
HAIR BLK
EYES BLU
HGT 5'11"
WGT 185LB
US 11/05/2001266737RP/AMER/19

Hospital Name
Address

Surgical Pathology Report

Patient: Doe, John
MRN: A11-8-199878
DOB: 07/08/1971
Gender: M

Accession Number: AF123456
Procedure: 03/15/2020
Attending: Dr. Mateo Jackson, MD

Clinical History: Large Gastric Mass

Specimen: Gastric Mucosa

Diagnosis

Stomach, Partial Gastrectomy:

- Malignant Epithelioid Gastrointestinal Stromal Tumor
- Tumor Size 10 x 9 x 8 cm
- Cell Type: Epithelioid and Spindled
- High cellularity; present
- Mucosal Invasion: Focally present adjacent to ulceration
- Mucosal ulceration present
- Mitotic Count: 10/50 HPF
- Myxoid background: Focally present
- Foci of necrosis present
- CD117, vimentin, and CD34: uniformly positive

Gross Description

The specimen consists of an approximately 5 x 7 cm portion of gastric mucosa that is surrounded and underlying by a lobulated mass which is 10 x 9 x 8 cm. The central portion of the mass appears to have an approximately 1.5-cm ulcer. The mucosa away from the area of ulceration is partially removed from the underlying tumor. The underlying mass appears encapsulated and lobular. Gross sections show the lesion to consist of several different patterns. A single area has a gray to gray-tan pattern with an area of central necrosis showing a fairly uniform appearance whereas; other regions of the tumor are gray white- and somewhat lobular in appearance. Areas of yellow necrosis are scattered through the tumor. Representative portions submitted.

Microscopic Description

Sections through the neoplasm show it to be primarily a high cellular neoplasm. The cells are in part arranged in fascicles and clusters with enlarged elongate nuclei having relatively find nucleoli. In some areas, the fascicles have an interwoven appearance. Mitotic figure up to 10:50 HPF. A few areas show foci of necrosis with the cells appearing to be surrounded by somewhat myxoid stroma. Foci of displayed necrosis are present. The lesions appear circumscribed, although not specifically encapsulated. It focally involved the mucosa and shows full thickness ulceration. The tumor immediately beneath the mucosal area of ulceration has a nearly lobular somewhat spindled growth pattern. Some areas of the tumor have a slightly more rounded nuclei and somewhat epithelioid appearance. The cells appear to be arranged in groups and clusters. Some of the cells have cyptoplasmic vacuoles. These areas also show a prominent mitotic activity. Some mitotic figured are abnormal and atypical. The tumor contains numerous relatively open vascular channels which appear to be part of the neoplasm. The tumor has a pseudo capsule and in some areas appear to be nearly covered.

Immunostains are strongly positive for CD117 (C-kit), CD34, and Vimentin, Smooth muscle actin, Desmin, Synaptophysin, S-100, and Ck8/18 are negative.

Comment

Immunostains were performed on the core biopsy and demonstrate that the tumor cells are positive for CD117. The findings are consistent with the above diagnosis.