HEALTH INSURANCE CLAIM FORM

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

CLARITY DX WC
PO BOX 540236
Orlando, FL 32854

CARRIER

PICA ☐☐☐ 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)	
	2024122195101	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH DOLORES N	3. PATIENT'S BIRTH DATE MM DD YY 03 19 1961 SEX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH DOLORES N
5. PATIENT'S ADDRESS (No., Street) 18170 93RD ROAD NORTH	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) SAME
CITY LOXAHATCHEE STATE FL	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE 33470 TELEPHONE (Include Area Code) (561) 596 5386		ZIP CODE TELEPHONE (Include Area Code) ( )
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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY 03 19 1961 SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☒ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☒ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	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 Signature On File DATE 12/10/24

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. 439 MM 10 DD 08 YY 2024	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Hallenbeck Ria FL	17a. 17b. NPI 1730585381	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 05 24 TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. S73191A B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 20241221951 01

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 12052024	12052024	11		73721	RT	A	2,439 00	1		NPI	1184886582
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 650378614 ☐ ☒	26. PATIENT'S ACCOUNT NO. 005901145911	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 2,439 00	29. AMOUNT PAID $ 0 00	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.) SIGNATURE ON FILE 12/10/24 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION DCA FL Wellington 2565 S State Road 7 Wellington FL 33414-9368 a. 1730125261 b.	33. BILLING PROVIDER INFO & PH # RAYUS RADIOLOGY ( ) PO BOX 745918 Los Angeles CA 90074-5918 a. 1730125261 b.			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION