CLARITY DX
PO BOX 540236
ORLANDO FL 32854

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) X (ID#)	2025122531
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WHETZEL SHAWNA	3. PATIENT'S BIRTH DATE: 09 10 1978 SEX: M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): WHETZEL SHAWNA	
5. PATIENT'S ADDRESS (No., Street): 3017 NE 24 CT	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 3017 NE 24 CT	
CITY: OCALA STATE: FL	8. RESERVED FOR NUCC USE
CITY: OCALA STATE: FL	
ZIP CODE: 34479 TELEPHONE (Include Area Code): (231)409-2778	
ZIP CODE: 34479 TELEPHONE (Include Area Code): (231)409-2778	
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) X YES NO
a. INSURED'S DATE OF BIRTH: 09 10 1973 SEX: M X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: CLARITY DX	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X 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 01142025

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): 12 01 24 QUAL 431	15. OTHER DATE QUAL
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CURNAYN, JAMES	17a. 17b. NPI 1366960049
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 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. S83.011A B. M71.21 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 2025122531

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 01 09 25	01 09 25	11		73721	RT	AB	1600 00	1		NPI	1235770686
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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. Rsvd for NUCC use
810607616 X	001/543385	X YES NO	$ 1600 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. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (352)241-6100
CLERMONT RADIOLOGY LLC SIGNED 01142025 DATE	CLERMONT RADIOLOGY-OCALA 18 NE 1ST AVE OCALA FL 34470 a. 1235770686 b.	CLERMONT RADIOLOGY LLC PO BOX 593869 ORLANDO FL 32859 a. 1235770686 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB 0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
SECOND FOLD
FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS