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	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#)	☒ (ID#)	2024122216101

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
GONZALEZ GUILLERMO	11 06 1987 M ☒ F ☐	GONZALEZ GUILLERMO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
3800 N JOG RD	Self ☒ Spouse ☐ Child ☐ Other ☐	SAME
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
WEST PALM BEACH / FL		
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
33411 / (561) 201 9743		( )
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 / SEX: 11 06 1987 M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	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 12/31/24

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 DD YY 12 09 2024	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 9 TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Washington Christiane FL	17a. / 17b. NPI 1295161685	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 28 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		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. M51370 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 12282024	12282024	11		72120		A	156 00	1		NPI	1801899042
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
650378614 ☐ ☒	005901177978	☒ YES ☐ NO	$ 156 00	$ 0 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 #
SIGNATURE ON FILE 12/31/24 SIGNED DATE	DCA FL West Palm Beach 1572 Palm Beach Lakes Blvd Ste 2 West Palm Beach FL 33401-2338 a. 1730126261 b.	RAYUS RADIOLOGY ( ) PO BOX 745918 Los Angeles CA 90074-5918 a. 1730125261 b.