HEALTH INSURANCE CLAIM FORM

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

CLARITY dx
PO BOX 3244
FAX 407-598-5395
MILWAUKEE, WI 532013244

PICA ☐ PICA ☐

1. MEDICARE (Medicare#) ☐	MEDICAID (Medicaid#) ☐	TRICARE (ID#/DoD#) ☐	CHAMPVA (Member ID#) ☐	GROUP HEALTH PLAN (ID#) ☐	FECA BLK LUNG (ID#) ☐	OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							TRF22034439		

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)
THORNTON , ANETRA	12 23 1974 M ☐ F X	THORNTON, ANETRA
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
136 TWIN LAKES CT	Self X Spouse ☐ Child ☐ Other ☐	136 TWIN LAKES CT
CITY: BYRON / STATE: GA	8. RESERVED FOR NUCC USE	CITY: BYRON / STATE: GA
ZIP CODE: 31008 / TELEPHONE (Include Area Code): (321) 6972401		ZIP CODE: 31008 / TELEPHONE (Include Area Code): (321) 6972401
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
		RADIOLOGY ONLY
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 12 23 1974 M ☐ F X
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: CLARITY dx
d. INSURANCE PLAN NAME OR PROGRAM NAME	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: SIGNATURE ON FILE DATE: 09/26/2024

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. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN HUGH SMISSON MD	17a. ☐ 17b. NPI 1922054998	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ☐ NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M54.51 B. M54.16 C. D. E. F. G. H. I. J. K.

22. RESUBMISSION CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

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. #
09 26 24	09 26 24	11		72148		AB	3113 00	1		NPI	1922054998
										NPI	
										NPI	
										NPI	
										NPI	
										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
581036115 ☐ X	GNI79193A3	X YES ☐ NO	$ 3113 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 # ( )
HUGH SMISSON MD	GEORGIA NEUROSURGICAL INSTITUTE 840 PINE ST, STE 880 MACON, GA 312012100	GEORGIA NEUROSURGICAL INSTITUTE, PC 840 Pine Street, STE 880 MACON, GA 312017525
SIGNED 01/_3/2025 DATE	a. 1972558336 b.	a. 1972558336 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