MQ GBL CLARITY DX WC
PO BOX 540236

ORLANDO FL 328540236

HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 202492028402
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RUFF, DENNIS	3. PATIENT'S BIRTH DATE MM DD YY: 02 20 1979 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): LEGGETT AND PLA,
5. PATIENT'S ADDRESS (No., Street): 110 8TH AVE NW	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street): PO BOX 140
CITY: CONOVER STATE: NC	8. RESERVED FOR NUCC USE	CITY: LINWOOD STATE: NC
ZIP CODE: 28613 TELEPHONE (Include Area Code): ( )		ZIP CODE: 27299 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) [X] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY: 08 08 1888 SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):	b. OTHER CLAIM ID (Designated by NUCC): Y4 202492028401
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT? [ ] YES [X] 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 [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

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 09 10 2024	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 FABIENNE RANSOM	17a. 17b. NPI 1275753287	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): WC LEFT KNEE INJURY		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M47816 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 202492028401

	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	10 13 24	10 13 24	49		72148		A	2497 00	1		NPI	1316205628
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 562016235 [ ] [X]	26. PATIENT'S ACCOUNT NO.: E0719990394270	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 2497 00	29. AMOUNT PAID: $	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.) YIN J CHEN SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION NOVANT HEALTH IMAGING MOORESVIL 118 GATEWAY BLVD STE E MOORESVILLE, NC 281176542 a. 1215080536 b.		33. BILLING PROVIDER INFO & PH # (704) 384-7840 NOVANT HEALTH IMAGING MOORESVILLE PO BOX 603543 CHARLOTTE, NC 282603543 a. 1215080536 b.		