CLARITY WC
PO BOX 540236

ORLANDO, FL 32854

100197816599

HEALTH INSURANCE CLAIM FORM

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

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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)	
	2024102119401	
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)
SCHENARTS, NICHOLAS	10 29 1993 M ☒ F ☐	SCHENARTS, NICHOLAS
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
18 STONEHEIGHTS DRIVE	Self ☐ Spouse ☐ Child ☐ Other ☒	18 STONEHEIGHTS DRIVE
CITY: WATERFORD — STATE: CT	8. RESERVED FOR NUCC USE	CITY: WATERFORD — STATE: CT
ZIP CODE: 06385 — TELEPHONE (Include Area Code): ( )		ZIP CODE: 06385 — 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 / SEX: 10 29 1993 M ☒ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) CT	b. OTHER CLAIM ID (Designated by NUCC): SY 2024102119401
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 11/26/2024

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: 11 26 2024 QUAL. 431	15. OTHER DATE QUAL. 439 MM DD YY: 11 26 2024	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNDANIEL VELTRI	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
	17b. NPI 1457321796	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PWKOZELAC10240841077		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.: 2024102119401
A. M25552 B. S73192A C. D. E. F. G. H. I. J. K. L.		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. #
1 INJECTION FOR HIP X-RAY 11 26 24 11 26 24	11		27093	LT	A	69000	1		NPI	1992096846
2 NEEDLE LOCALIZATION BY XRAY 11 26 24 11 26 24	11		77002		A	39000	1		NPI	1992096846
3 N400270-1315-30 ML5.000 ISOVUE 612 MG/ML 11 26 24 11 26 24	11		Q9967		A	055	5		NPI	1992096846
4 N470069-0064-01 ML25.000 Ropivacaine Hydrochloride 5 MG/ML 11 26 24 11 26 24	11		J2795		A	100	25		NPI	1992096846
5 MRI JOINT OF LWR EXTR W/DYE 11 26 24 11 26 24	11		73722	LT	B	145000	1		NPI	1730408261
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
824890700 ☐ ☒	2423934X1	☒ YES ☐ NO	$ 253155	$	

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 # (888) 432-8978
OSAMU KANEKO	GUILFORD RADIOLOGY LLC 1591 BOSTON POST RD 106 GUILFORD, CT 064374335	GUILFORD RADIOLOGY LLC PO BOX 411034 BOSTON, MA 022411034
SIGNED 12/12/2024 DATE	a. b.	a. 1760593347 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION