Submitted:
12/12/2024

CIC# 42736414

CLARITY DX
PO BOX 540236
ORLANDO, FL 32854

# 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 [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 20241121679

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ROSARIO, RICHARD

3. PATIENT'S BIRTH DATE MM DD YY: 11 08 90 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CLARITY DX WC

5. PATIENT'S ADDRESS (No., Street): 2519 OUTER JAKE ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): NOT AVAILABLE

CITY: ORANGE CITY STATE: FL

8. RESERVED FOR NUCC USE

CITY: NOT AVAILABLE STATE: FL

ZIP CODE: 32763 TELEPHONE (Include Area Code): ( )

ZIP CODE: 32763 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: SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC): Y4 20241121679

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: 12/12/2024

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 27 24 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 11 27 24

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN BENJAMIN THOMASSON

17a.

17b. NPI 1396078200

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY 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. M25471 B. M65971 C. R600 D. M67873

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: G1 20241121679

| 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. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 11 27 24 | 11 27 24 | 11 | | 73721 | RT | ABCD | 1193 00 | 1.00 | | 0B | 036075337 |
| | | | | | | | | | | NPI | 1144207416 |
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| | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN: 453727094 [ ] [X]

26. PATIENT'S ACCOUNT NO.: SMF94648412

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 1193 00

29. AMOUNT PAID: $ 0 00

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.)

JEFFREY BERNFIELD
036075337 12/12/2024
SIGNED On File DATE

32. SERVICE FACILITY LOCATION INFORMATION
SIMONMED IMAGING - ORANGE CITY
1639 N VOLUSIA AVE
ORANGE CITY, FL 327633843

a. b.

33. BILLING PROVIDER INFO & PH # (888 )976-7781
SIMONMED IMAGING FLORIDA LLC
PO BOX 203573
DALLAS, TX 753203573

a. 1477830818 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

*PLEASE PRINT OR TYPE*

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