IEALTH INSURANCE CLAIM FORM

CLARITY W/C
PO BOX 3244
MILWAUKEE WI 53201

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

☐ PICA — PICA

1. MEDICARE ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID/DoD#)	CHAMPVA ☐	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☑ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 2024419973 01

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)
RICH, JUSTUS	10 17 2000	M ☑ F ☐	RICH, JUSTUS

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
6952 WELLSFORD DR	Self ☑ Spouse ☐ Child ☐ Other ☐	6952 WELLSFORD DR

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
LAKELAND	FL		LAKELAND	FL

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
33809	( )	33809	( )

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. EMPLOYMENT? (Current or Previous) ☑ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY: 10 17 2000 SEX M ☑ F ☐
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☑ NO	b. OTHER CLAIM ID (Designated by NUCC)
b. RESERVED FOR NUCC USE	c. OTHER ACCIDENT ☐ YES ☑ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☑ No If yes, complete items 9, 9a, and 9d
d. INSURANCE PLAN NAME OR PROGRAM NAME		

READ BACK FORM 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 11 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.	431	15. OTHER DATE MM DD YY	QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM To MM DD YY
08 13 2024					

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM To MM DD YY
DN STOKES, NICOLE	17b	NPI 1255639142	

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. S39012A	B. S76011A	C. S161XXA	D.
E.	F.	G.	H.
I.	J.	K.	L.

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 11 2024	09 11 2024	11		73721		B	2440	00	1	NPI	1982925269
09 11 2024	09 11 2024	11		72148		A	2440	00	1	NPI	1982925269
09 11 2024	09 11 2024	11		72141		C	2440	00	1	NPI	1982925269
										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 U
272366208	☐	☑	727873	☑ YES ☐ NO	$ 7320 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 # (813) 210-9237
HIGHLAND, MRI NPI: 1982925269 SIGNED Thomas Olcott 09 11 2024	HIGHLAND MRI 2946 LAKELAND HIGHLANDS RD LAKELAND FL 338034379	MRI ASSOCIATES OF LAKELAND LLC PO BOX 2570 BRANDON FL 335092570
a. 1982925269 b.	a. 1982925269	b. ME27052

NUCC Instruction Manual available at www.nucc.org — PLEASE PRINT OR TYPE — CR0615E2 — APPROVED OMB-0938-1197 FORM 1500 (02-12)