HEALTH INSURANCE CLAIM FORM

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

PICA

CLARITY W/C
PO BOX 3244
MILWAUKEE WI 53201

PICA

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): 2024920041-01

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)
RHYMES, SHEILA	03 13 1972 / M ☐ F ☑	RHYMES, SHEILA
5. PATIENT'S ADDRESS (No., Street): PO BOX 21484	6. PATIENT'S RELATIONSHIP TO INSURED: Self ☑ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): PO BOX 21484
CITY: BRADENTON / STATE: FL	8. RESERVED FOR NUCC USE	CITY: BRADENTON / STATE: FL
ZIP CODE: 34204 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 34204 / 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. EMPLOYEMENT? (Current or Previous) ☑ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 13 1972 / M ☐ F ☑
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☑ NO	b. OTHER CLAIM ID (Designated by NUCC)
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 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 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	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
08 14 2024 QUAL. 431	QUAL.	FROM To
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CHOY, JOHN	17a / 17b NPI: 1750458220	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. R1084 B. C. 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 12 2024	09 12 2024	11		74178		A	1990	00	1	NPI	1629183595
09 12 2024	09 12 2024	11		71270		A	1990	00	1	NPI	1629183595
09 12 2024	09 12 2024	11		Q9967		A	150	00	100	NPI	1629183595
										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
810980506	☐	☑	727924	☑ YES ☐ NO	$ 4130 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 #
SARASOTA, MRI NPI: 1629183595 Paul Card 09 12 2024 SIGNED DATE	SARASOTA MRI 2 NORTH TUTTLE AVE SARASOTA FL 342376328 a. 1629183595 b.	(813) 210-9237 MRI ASSOCIATES OF SARASOTA, LLC PO BOX 2570 BRANDON FL 335092570 a. 1629183595 b. ME108034

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