Submitted:
1/2/2025

CIC# 43261327

CLARITY WORK COMP
PO BOX 540236
ORLANDO, FL 328540236

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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): 2024112185001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WARNER, KEVIN

3. PATIENT'S BIRTH DATE: 01 | 22 | 61 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ORANGE COUNTY SHERRIFF DEPT

5. PATIENT'S ADDRESS (No., Street): 1119 FISH TRAPP ROAD

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

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

CITY: LAWRENCEBURG STATE: TN

8. RESERVED FOR NUCC USE

CITY: NOT AVAILABLE STATE: TN

ZIP CODE: 38464 TELEPHONE (Include Area Code): ( )

ZIP CODE: 38464 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 2024112185001

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CLARITY WORK COMP

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: 1/2/2025

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): 12 | 28 | 24 QUAL. 431

15. OTHER DATE: QUAL. 439 12 | 28 | 24

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CLINTON MORGAN

17a.

17b. NPI 1316392426

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. M4802 B. M5020 C. M4723 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. #
12 28 24	12 28 24	11		72141		ABC	1888 45	1.00		NPI	1164461315
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 010570490 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: PMR1160943

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

28. TOTAL CHARGE: $ 1888 45

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.)

JAMES KING III

SIGNED On File DATE 1/2/2025

32. SERVICE FACILITY LOCATION INFORMATION
PREMIER RADIOLOGY HERMITAGE
5045 OLD HICKORY BLVD STE 100
HERMITAGE, TN 370762581

a. b.

33. BILLING PROVIDER INFO & PH # (615) 747-2984
MIDDLE TENNESSEE IMAGING
PO BOX 306511
NASHVILLE, TN 372306511

a. 1770667289 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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