Submitted:
12/14/2024

CIC# 42810735

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): 2024122189101

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REVADAVIA, VICTOR

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 58 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 340 GRAND BLVD 19

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

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

CITY: SAN MATEO STATE: CA

8. RESERVED FOR NUCC USE

CITY: NOT AVAILABLE STATE: CA

ZIP CODE: 94401 TELEPHONE (Include Area Code): ( )

ZIP CODE: 94401 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 2024122189101

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: 12/14/2024

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: 12 04 24 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 12 04 24

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ALAN SPIRA

17a.

17b. NPI 1194726075

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. S83512A 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. #
12 04 24	12 04 24	11		73721	LT	A	1193 00	1.00		0B	2081571
										NPI	1922075365
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 943292479 [X]

26. PATIENT'S ACCOUNT NO.: HDC79299818

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.)

MARLENA JBARA
2081571
SIGNED On File DATE 12/14/2024

32. SERVICE FACILITY LOCATION INFORMATION
SIMONMED IMAGING - DALY CITY
455 HICKEY BLVD STE 200
DALY CITY, CA 940152630

a. b.

33. BILLING PROVIDER INFO & PH # (888) 976-7781
HEALTH DIAGNOSTIC OF CA A PROFESSIONAL CORP
PO BOX 203557
DALLAS, TX 753203557

a. 1104321959 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION