Submitted:
12/12/2024

CIC# 42736416

CLARITY DX
PO BOX 540236
ORLANDO, FL 32854

HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 202471920301

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MAISEL, KEITH

3. PATIENT'S BIRTH DATE: 07 21 60 SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 11143 ENCANTO TERRACE

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

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

CITY: BRADENTON STATE: FL

8. RESERVED FOR NUCC USE

CITY: NOT AVAILABLE STATE: FL

ZIP CODE: 34211 TELEPHONE (Include Area Code): ( )

ZIP CODE: 34211 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: SEX: M | F

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC): Y4 202471920301

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): 12 05 24 QUAL. 431

15. OTHER DATE: QUAL. 439 12 05 24

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SATINDERPAUL SATIA

17a.

17b. NPI 1801083175

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY

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. M5127 B. M9974 C. M4186 D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: G1 A230976823

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	05	24	12	05	24	11		72148		ABC	1529 00	1.00		0B	ME159285
														NPI	1376504472
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	

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

26. PATIENT'S ACCOUNT NO.: SMF94134324

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

28. TOTAL CHARGE: $ 1529 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.)

SNEHA PATEL
ME159285 12/12/2024
SIGNED On File DATE

32. SERVICE FACILITY LOCATION INFORMATION
SIMONMED IMAGING - LAKEWOOD RANCH
10910 STATE RD 70 E STE 103
LAKEWOOD RANCH, FL 342028406

a. b.

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

a. 1477830818 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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