CLARITY DX
PO BOX 3244
MILWAUKEE WI 53201

# HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

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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) | |
| | 202512254601 | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARDY DORIS | 3. PATIENT'S BIRTH DATE MM 02 DD 19 YY 66 SEX M [ ] F [X] | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARDY DORIS |
| 5. PATIENT'S ADDRESS (No., Street) 3950 SW 115 TER | 6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ] | 7. INSURED'S ADDRESS (No., Street) 3950 SW 115 TER |
| CITY OCALA STATE FL | 8. RESERVED FOR NUCC USE | CITY OCALA STATE FL |
| ZIP CODE 34481 TELEPHONE (Include Area Code) (352) 207-0411 | | ZIP CODE 34481 TELEPHONE (Include Area Code) (352) 207-0411 |
| 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 02 DD 19 YY 66 SEX M [ ] F [X] |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) |
| 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. |

SECOND FOLD

PATIENT AND INSURED INFORMATION

**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 01142025

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 11 DD 19 YY 24 QUAL. 431 | 15. OTHER DATE QUAL. MM DD YY | 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 CURNAYN, JAMES E | 17a. 17b. NPI 1366960049 | 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<br>A. M54.6 B. C. D.<br>E. F. G. H.<br>I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER 202512254601 |

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

| 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. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 01 09 25 01 09 25 | 11 | | 72146 | | A | 1600 00 | 1 | | NPI | 1235770686 |
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| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

PHYSICIAN OR SUPPLIER INFORMATION

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|---|---|---|---|---|---|
| 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 use |
| 810607616 [ ] [X] | 001/544489 | [X] YES [ ] NO | $ 1600 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.) CLERMONT RADIOLOGY LLC SIGNED 01142025 DATE | 32. SERVICE FACILITY LOCATION INFORMATION CLERMONT RADIOLOGY-OCALA 18 NE 1ST AVE OCALA FL 34470 a. 1235770686 b. | | 33. BILLING PROVIDER INFO & PH. # (352) 241-6100 CLERMONT RADIOLOGY LLC PO BOX 593869 ORLANDO FL 32859 a. 1235770686 b. | | |

PLEASE PRINT OR TYPE