Submitted:
12/15/2024

CIC# 42823078

CLARITY DX
PO BOX 540236
ORLANDO, FL 32854

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 20241121789

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)
AVEYTIA, PORFIRIO	11 06 52 M(X) F( )	CLARITY DX WC
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
2982 W ATCHISON ST	Self( ) Spouse( ) Child( ) Other(X)	NOT AVAILABLE
CITY: RIALTO / STATE: CA	8. RESERVED FOR NUCC USE	CITY: NOT AVAILABLE / STATE: CA
ZIP CODE: 92376 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 92376 / 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 20241121789
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: 12/15/2024

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	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
12 06 24 QUAL. 431	QUAL. 439 MM DD YY: 12 06 24	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ANTO FRITZ	17a. / 17b. NPI: 1841528718	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.	B.	C.	D.
M48061	M4316	M47816	
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 06 24	12 06 24	11		72131		ABC	921 00	1.00		0B	CAA102215
										NPI	1871757005
										NPI	
										NPI	
										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 Use
943292479	( ) (X)	HDC79108509	(X) YES ( ) NO	$ 921 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 # (888) 976-7781
KAMRON IZADI CAA102215 12/15/2024 SIGNED On File DATE	SIMONMED IMAGING - SAN BERNARDINO 225 W HOSPITALITY LN STE 100 SAN BERNARDINO, CA 924083244 a. / b.	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