MQ GBL CLARITY DX WC
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): 202492036201

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KEARNEY, MARVIN

3. PATIENT'S BIRTH DATE MM DD YY: 04 06 1954 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KM08232024STAFF,

5. PATIENT'S ADDRESS (No., Street): 1007 ARDMORD DR

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

7. INSURED'S ADDRESS (No., Street): 617 N ENGLISH ST

CITY: GREENSBORO STATE: NC

8. RESERVED FOR NUCC USE

CITY: GREENSBORO STATE: NC

ZIP CODE: 27401 TELEPHONE (Include Area Code): ( )

ZIP CODE: 27405 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: 04 05 1954 SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): Y4 202492036201

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

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 QUAL.

15. OTHER DATE QUAL. 439 MM DD YY: 08 23 2024

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 08 23 2024 TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN GREGORY DEAN

17a.

17b. NPI 1639116684

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): WC NECK INJURY

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M75122 B. M19012 C. M25412 D. M67912

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 202492036201

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 10 14 24	10 14 24	49		73221	LT	ABCD	1956 00	1		NPI	1902836448
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 562001223 [ ] [X]

26. PATIENT'S ACCOUNT NO.: E0713991545440

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

28. TOTAL CHARGE: $ 1956 00

29. AMOUNT PAID: $

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.)

PATRICK S MARKWALTER

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

NOVANT HEALTH IMAGING TRIAD
2705 HENRY ST
GREENSBORO, NC 274053669

a. 1790743078 b.

33. BILLING PROVIDER INFO & PH # (704) 384-7840

NOVANT HEALTH IMAGING TRIAD
PO BOX 603543
CHARLOTTE, NC 282603543

a. 1790743078 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION