CLARITY DX WC
PO BOX 540236

Orlando, FL 32854

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

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): 2024122199001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): VENTURA NELSON

3. PATIENT'S BIRTH DATE MM DD YY: 02 22 1971 — SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 216 SE 1ST AVE

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

7. INSURED'S ADDRESS (No., Street): SAME

CITY: DELRAY BEACH — STATE: FL

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE: 33444 — TELEPHONE (Include Area Code): (305) 834 5392

ZIP CODE — 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: 02 22 1971 — SEX: M [ ] F [ ]

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?: [X] YES [ ] 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 [ ] 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: 12/31/24

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 439 — MM DD YY: 11 19 2024

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY: 9 — TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN KROM CALVIN FL

17a. — 17b. NPI: 1003249301

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY: 12 18 24 — TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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. S62001A — B. S62121A — C. — D.

E. — F. — G. — H.

I. — J. — K. — L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 20241221990 01

	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	12182024	12182024	11		73221	RT	A,B	2,439 00	1		NPI	1710930433
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 650378614 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 005901164482

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

28. TOTAL CHARGE: $ 2,439 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.)

SIGNATURE ON FILE

SIGNED — DATE: 12/31/24

32. SERVICE FACILITY LOCATION INFORMATION
DCA FL East Boynton Beach
1425 Gateway Boulevard Ste 100
Boynton Beach FL 33426-8313

a. 1730125261 — b.

33. BILLING PROVIDER INFO & PH # ( )
RAYUS RADIOLOGY
PO BOX 745918
Los Angeles CA 90074-5918

a. 1730125261 — b.