HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0576444

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Finn, Nemo B

3 PATIENT'S BIRTH DATE: 08 | 16 | 03 SEX: M [X] F [ ]

4 INSURED'S NAME (Last Name, First Name, Middle Initial): Finn, Merlin S

5 PATIENT'S ADDRESS (No., Street): 42 Wallaby Way

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

7 INSURED'S ADDRESS (No., Street): 42 Wallaby Way

CITY: Sydney STATE: AL

8 RESERVED FOR NUCC USE

CITY: Sydney STATE: AL

ZIP CODE: 59876 TELEPHONE (Include Area Code): (231) 1234567

ZIP CODE: 59876 TELEPHONE (Include Area Code): (231) 1234567

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: RE351414

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: 05 | 04 | 88 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Deep Sea Health

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETNG & SIGNNG 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: Nemo Finn DATE: 05/17/18

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: Merlin Finn

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 | 21 | 06 QUAL: bad

15 OTHER DATE QUAL: MM | DD | YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 02 | 09 | 08 TO 02 | 15 | 10

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dre Young

17a:

17b NPI:

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 02 | 28 | 12 TO 04 | 06 | 14

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20 OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

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

A. B. C. D.

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. #
1	12 5 99	02 08 00	11	55	99213	24		305.88			NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25 FEDERAL TAX I.D. NUMBER: 487-89-4578 SSN EIN: X

26 PATIENT'S ACCOUNT NO.: 357634

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

28 TOTAL CHARGE: $ 2152.64

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.)

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION: 825 Ocean Dr Pacific, OR 43267

a. NPI b.

33 BILLING PROVIDER INFO & PH #: (587) 4578962 712 Coral Rd Waterfall, AK 44573

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 316754 42

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Holmes Phillip T

3. PATIENT'S BIRTH DATE: 02 28 70 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Holms phillip T

5. PATIENT'S ADDRESS (No., Street): 888 Strawberry lane

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

7. INSURED'S ADDRESS (No., Street): 888 strawberry Lane

CITY: Paris STATE: mo

8. RESERVED FOR NUCC USE

CITY: Paris STATE: mo

ZIP CODE: 65812 TELEPHONE (Include Area Code): (660) 800 5430

ZIP CODE: 65812 TELEPHONE (Include Area Code): (660) 800 5430

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: 6657

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH: 02 28 70 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross

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 Phil Holms DATE 7/24/09

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 Phil Holms

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 05 08 2000 QUAL: bad

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 05 08 2000 TO 05 08 2000

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Tiffany Jones

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 04 12 2000 TO 04 12 2000

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 0.00

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

A. E00-E90 B. C. D.

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. #
1 09 12 00	09 25 00	ER	11	99213	21		62 78			NPI	12353199
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 321876845 SSN EIN

26. PATIENT'S ACCOUNT NO.: TLR95D

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

28. TOTAL CHARGE: $ 62 78

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: 53547 Lumby Lane Chicago IL 68473

a. NPI b.

33. BILLING PROVIDER INFO & PH #: ( ) Pon Bop Circle Boston pa 42588

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

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PLEASE PRINT OR TYPE

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HEALTH INSURANCE CLAIM FORM

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PICA

PICA

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

1a INSURED'S I D NUMBER (For Program in Item 1): 316354 Y32

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Holms, Phillip, T

3 PATIENT'S BIRTH DATE MM 02 DD 28 YY 70 SEX M [X] F [ ]

4 INSURED'S NAME (Last Name, First Name, Middle Initial): Holms, Phillip, T

5 PATIENT'S ADDRESS (No , Street): 888 Strawberry Lane

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

7 INSURED'S ADDRESS (No , Street): 888 Strawberry Lane

CITY: Paris STATE: MO

8 RESERVED FOR NUCC USE

CITY: Paris STATE: MO

ZIP CODE: 65812 TELEPHONE (Include Area Code): (680) 8005430

ZIP CODE: 65812 TELEPHONE (Include Area Code): (680) 8005430

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: G657

a OTHER INSURED'S POLICY OR GROUP NUMBER:

a EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a INSURED'S DATE OF BIRTH MM 02 DD 28 YY 70 SEX M [X] F [ ]

b RESERVED FOR NUCC USE:

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

b OTHER CLAIM ID (Designated by NUCC):

c RESERVED FOR NUCC USE:

c OTHER ACCIDENT? YES [ ] NO [ ]

c INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross

d INSURANCE PLAN NAME OR PROGRAM NAME:

10d CLAIM CODES (Designated by NUCC):

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETNG & 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: Phil Holms DATE: 7/28/09

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: Phil Holms

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 05 DD 08 YY 2000 QUAL bad

15 OTHER DATE QUAL MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 05 08 2000 TO 05 08 2000

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: Tiffany Jones

17a

17b NPI

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 12 2000 TO 04 12 2000

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0 00

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

A E00-E90 B C D 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. #
1 07 12 00	09 25 00	ER	11	99213	21		82 78			NPI	1245319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25 FEDERAL TAX I D NUMBER SSN EIN: 321 876845

26 PATIENT'S ACCOUNT NO: tLKASD

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

28 TOTAL CHARGE $ 82 78

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.)

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION: 53547 Lurry Lane Chicago, IL 84873

a NPI b

33 BILLING PROVIDER INFO & PH # (653) 354 3248 Doc Bop Circle Boston, PA 42588

a NPI b

CARRIER

PATIENT AND INSURED INFORMATION

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HEALTH INSURANCE CLAIM FORM

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PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 23435023

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jone, Mary L

3. PATIENT'S BIRTH DATE: 03 | 19 | 70 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Jone, Mary L

5. PATIENT'S ADDRESS (No., Street): 42713 Steety Dr

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

7. INSURED'S ADDRESS (No., Street): 42713 Steety Dr

CITY: Springfield STATE: MA

8. RESERVED FOR NUCC USE

CITY: Springfield STATE: MA

ZIP CODE: 65432 TELEPHONE (Include Area Code): (28) 555-1145

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

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

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

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: 12345487

a. INSURED'S DATE OF BIRTH: 03 | 19 | 70 SEX: M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: My Homestate Health

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] 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 _____ 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 _____

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

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

17a

17b NPI

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

A B C D

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. #
1	01 02 19	01 05 19					419.39	3		NPI	1245319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b

33. BILLING PROVIDER INFO & PH # ( )

a NPI b

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 23435023

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jone, Mary L

3. PATIENT'S BIRTH DATE: MM 03 DD 19 YY 70 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Jone, Mary L

5. PATIENT'S ADDRESS (No., Street): 42713 Steety Dr

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

7. INSURED'S ADDRESS (No., Street): 42713 Steety Dr

CITY: Springfield | STATE: MA

8. RESERVED FOR NUCC USE

CITY: Springfield | STATE: MA

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

ZIP CODE: 65432 | TELEPHONE (Include Area Code): (213) 5551145

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: 123454567

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: MM 03 DD 19 YY 70 | SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: MyHomestate Health

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] 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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 01 DD 02 YY 19 QUAL

15. OTHER DATE: QUAL | MM | DD | YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b. NPI

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

A K35.2 B C D

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. #
1	01 02 19	01 05 19					419 39			NPI	1245319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b

33. BILLING PROVIDER INFO & PH # ( )

a NPI b

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER: 3116Kh87 (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mars, Veronica R

3. PATIENT'S BIRTH DATE: 03 15 92 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Mars, Keith L

5. PATIENT'S ADDRESS (No., Street): 4482 Jefferson St. Apt 23

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

7. INSURED'S ADDRESS (No., Street): 4482 Jefferson St. Apt 23

CITY: Neptune | STATE: CA

8. RESERVED FOR NUCC USE

CITY: Neptune | STATE: CA

ZIP CODE: 87155 | TELEPHONE (Include Area Code): (878) 548-3257

ZIP CODE: 87155 | TELEPHONE (Include Area Code): (878) 872 4872

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: JFF872

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH: 10 31 69 SEX: M X F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Neptune Healthcare

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: Veronica Mars DATE: 8/12/03

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: Keith Mars

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 07 12 13 QUAL: Sime

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 05 11 2018 TO 02 08 2020

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Will Grace

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 06 13 2008 TO 03 22 2012

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? X YES NO $ CHARGES: 1000.01

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

A. E00.0 E90 B. C. D.

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. #
1 09 12 00	09 25 00	11		99213	21		94			NPI	1245319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 326879832 SSN EIN

26. PATIENT'S ACCOUNT NO.: tL66Ku8

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

28. TOTAL CHARGE: $ 94

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: 84357 Stacy Rd Springfield OR 79845

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (654) 557-9816 CandyCane Loop North Pole, LA 67662

a. NPI 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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 316kh87

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mars, Veronica R

3. PATIENT'S BIRTH DATE: 03 15 92 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Mars Keith L

5. PATIENT'S ADDRESS (No., Street): 4482 Jefferson St Apt 23

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

7. INSURED'S ADDRESS (No., Street): 4482 Jefferson St Apt 23

CITY: Neptune STATE: CA

8. RESERVED FOR NUCC USE

CITY: Neptune STATE: CA

ZIP CODE: 87155 TELEPHONE (Include Area Code): (878)5483257

ZIP CODE: 87155 TELEPHONE (Include Area Code): (878)8724872

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: jctr872

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: 10 31 69 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Neptune Healthcare

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] 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: Veronica Mars DATE: 8/12/03

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: Keith Mars

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 07 12 2018 QUAL: fine

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 05 11 2018 TO 02 08 2020

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Will Grace

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 06 13 2008 TO 03 22 2012

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 1000 01

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

A. E00-E90 B. C. D.

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. #
1	09 12 00	09 25 00	ER	11	99213	21				0.94			NPI	12453195599
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

25. FEDERAL TAX I.D. NUMBER: 326879832 SSN EIN

26. PATIENT'S ACCOUNT NO.: +LdoKu8

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

28. TOTAL CHARGE: $ 0.94

29. AMOUNT PAID: $ 0

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: 84357 Stacy Rd Springfield, OR 79845

a. NPI b.

33. BILLING PROVIDER INFO & PH#: (654)5579816 Candy Cane Loop North Pole, LA 67662

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): BR549

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hunt, Ethan S.

3. PATIENT'S BIRTH DATE: 09 | 11 | 1990 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 117 St. Clair St.

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

7. INSURED'S ADDRESS (No., Street): 117 St. Clair St.

CITY: Glendale STATE: TX

8. RESERVED FOR NUCC USE

CITY: Glendale STATE: TX

ZIP CODE: 76158 TELEPHONE (Include Area Code): (314)867-5309

ZIP CODE: 76158 TELEPHONE (Include Area Code): (314)867-5309

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): n/a

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: FY832IG0893

a. OTHER INSURED'S POLICY OR GROUP NUMBER: n/a

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH: 09 | 11 | 1990 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): n/a

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Insurance 'R US

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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 09 | 11 | 2019 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 09 | 11 | 2019 TO 09 | 27 | 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Brian Smith

17a

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 09 | 11 | 2019 TO 09 | 13 | 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 9,999.00

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

A. Head trauma B. Broken Femor (L) C. Broken Femor (R) D.

E. Broken Ulna (L) F. Broken Ulna (R) H.

I. J. K. L.

22. RESUBMISSION CODE: OU812 ORIGINAL REF. NO.: WTF73

23. PRIOR AUTHORIZATION NUMBER: BS123

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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED [signature] DATE 9/20/19

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1337 1337

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Leclerc, Charles

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 97 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 280 Washington St

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

7. INSURED'S ADDRESS (No., Street): 777 Brockton Ave

CITY: Hudson STATE: MA

8. RESERVED FOR NUCC USE

CITY: Abington STATE: MA

ZIP CODE: 01749 TELEPHONE (Include Area Code): (123) 456 7890

ZIP CODE: 02351 TELEPHONE (Include Area Code): (123) 0987 654

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: 123 123 123

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 10 10 97 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] 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: Charles Leclerc DATE: 09/27/19

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

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

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

17a

17b NPI

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.

A. B. C. D.

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. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION