

PICA MEDICARE MED	ICAID THICA	RE CHAM	PVA GROUP	BLAN SEC	OTHER	1a, INSURED'S I D. NUMBER		(For Program in Item 1)
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Doe, John I			1 1	60 ™>		Doe, John 1		
PATIENT'S ADDRESS (* 1234 Example :			6 PATIENT REL		NSURED Other	7. INSURED'S ADDRESS (No., 1234 Example Str		
тү St Louis		STAT		OR NUCC USE		οπγ St Louis		STATE
PCODE	TELEPHONE	(Include Area Code)	_			ZIP CODE	TELEPHON	E (Include Area Code)
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OTHER INSURED'S PO	JCY OR GROUP NU	MBER	a EMPLOYMEN	T? (Current or Pr	evious)	a. INSURED'S DATE OF BIRTH		SEX
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iliser i comocc	OSE		B. AOTO ACCID		PLACE (State)	b OTHER CLAIM ID (Designati	ed by NUCC)	
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NSURANCE PLAN NAM	E OR PROGRAM NA	AME	18d. CLAIM CCE	DES (Designated	by NUCC)	d. IS THERE ANOTHER HEALT	TH BENEFIT PL	AN?
		U DEFORE ACTION TO				YES X NO		te items 9, 9a, and 9d
PATIENT'S OR AUTHO to process this claim. Lat telow	RIZED PERSON'S SI		ne release of any med	ical or other inforn		13. INSURED'S OR AUTHORIZ payment of medical benefits services described below		SIGNATURE I authorize ned physician or supplier for
SIGNED John Do	e		DATE	8/21/2019		SIGNED John Doe		
DATE OF CURRENT IL	LNESS, INJURY, or F	PREGNANCY (LMP)	5. OTHER DATE	MM DD	YY	16. DATES PATIENT UNABLE	TO WORK IN C	CURRENT OCCUPATION
08 21 2019 NAME OF REFERRING	PROVIDER OR OTH	USA	17a			FROM 08 21 20 18 HOSPITALIZATION DATES		08 28 2019 CURRENT SERVICES
r Doctor Kno	ws-Stuff		17th NPI			FRCM 08 21 20	19 19	08 25 2019
ADDITIONAL CLAMIN	FORMATION (Design	nated by NUCC)				20. OUTSIDE LAB?  YES X NO		HARGES 1700, 00
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MEDICARE MEDICAL	D TRICARE	CHAMPVA	GROUP HEALTH PLA	n — EEKA	OTHER	1a. INSURED'S I D. NUMBER		(For Program i	PICA
(Medicares) (Medicald		(Member ID#)	ATIENT'S BIRTH	(IDA)	(10#)	316354Y32 4 INSURED'S NAME (Last Name	- Fact Marin	Advisor halberts	
Stark, Tony G		0.1	MM DD 6	YY _	SEX F	Stark, Tony G		Middle Initial)	
PATIENT'S ADDRESS (No., 8 1920 ImRich Lane	Street)		PATIENT RELATION		SURED Other	7. INSURED'S ADDRESS (No., 8 1920 ImRich Lane	reet)		
TY Hollywood		STATE B R	ESERVED FOR	NUCC USE		CITY Hollywood			STATE CA
CODE	TELEPHONE (Include Are	a Code)				ZIP CODE	TELEPHON	E (Include Area (	
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PATIENT'S OR AUTHORIZE to process this claim. I also re- tellow	D PERSON'S SIGNATURE	I authorize the releas	se of any medical i	or other informa		13. INSURED'S OR AUTHORIZED payment of medical benefits to services described below			
SIGNED Tony Stark			DATE 7/2	8/09		SIGNED Tony Stark			
DATE OF CURRENT ILLINES	1	Y (LMP) 15. OTHE	ER DATE	AM   DD	YY	16 DATES PATIENT UNABLE TO			
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Stark, Tony G	3 PATIENT'S BIRTH DATE SEX	Stark, Tony 6	a)
5 PATIENT'S ADDRESS (No , Steet)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Steet)	
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9 OTHER INSURED'S NAME (Last Name, First Name, A		11 INSURED'S POLICY GROUP OR FECA NUMBER	-3 ( )
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	YES NO	are) a crima recommo (pesigrated by Noce)	N N
C. RESERVED FOR NUCCUSE	c OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	5
	YES NO	Ironman Health	B
INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CCDES (Designated by NVCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?	
READ BACK OF FORM BEFG	ORE COMPLETING & SIGNING THIS FORM.	YES X NO If yes, complete items 9, 9 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATUR	
	IAE: I authorize the release of any medical or other information necessar nent benefits either to myself or to the party who accepts assignment.	79 payment of medical benefits to the undersigned physiciseruloes described below	
below C.)	7/28/09	7. N. C. V.	
SIGNED LONY STONK	DATE	SIGNED TONY STAIK	Y
M DOTE OF CURRENT ILLNESS, INJURY, & PREGNA	ANCY (LMP) 15 OTHER DATE OUAL MM   DD   YY	FRCM 07 05 2014 TO 05 0	
17 NAME OF REFERRING PROVIDER OR OTHER SO	URCE 17a	18 HOSPITALIZATION DATES RELATED TO CURRENT	SERVICES
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19 ADDITIONAL CLAIM INFORMATION (Designated by	NUCC)	20 OUTSIDE LAB? \$ CHARGES	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Rolate & Liniser viralina holow (249)		00
A 1200-E412 BI	ICD Ind	22 RESUBMISSION CRIGINAL REF NO	
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25 FEDERAL TAX I D NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT (FOT good claims, see bad.)		Rsvd.for NUCC Use
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31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH# (653) }5	43248
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APPROVED BY NATIONA	L UNIFORM CLAIM!	COMMITTEE	(NUCC) 02/12
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MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER   Medicares   (Medicares)	1a INSURED'S LD NUMBER (For Program in Item 1)  3 1 6 35 4 432
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX  MM 7 2869 MX F	4 INSURED'S NAME (Last Name, First Name, Middle Initial) Stark, Tony G
5. PATIENT'S ADDRESS (No., Steet) 6. PATIENT RELATIONSHIP TO INSURED  19.20 Twill whe Selt Spouse Child Other	7. INSURED'S ADDRESS (NO. Steel)
CITY STATE 8. RESERVED FOR NUCC USE	a with
ZIP CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Include Area Code)
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO	79575 (886) 57 25 97 11., IRISURED'S POUCY GROUP OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)	a. INSURED S DATE OF BIRTH SEX
b RESERVED FOR NUCC USE  b. AUTO ACCIDENT?  PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. OTHER ACCIDENT?	TELEPHONE (Include Area Code)  209575  (\$88)5712597  11.,INSURED'S POUCY GROUP OR FECA NUMBER  THO WAY  a. INSURED'S POUCY GROUP OR FECA NUMBER  THO WAY  DO OTHER CLAIM ID (Designated by NUCC)  C. INSURANCE PLAN NAME OR PROGRAM NAME  TO MAN  d IS THERE ANOTHER HEALTH BENEFIT PLAN?
d INSURANCE PLAN NAME OR PROGRAM NAME  10d CLAIM CODES (Designated by NUCC)	d is there another health benefit plan?
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S CRIAUTHCRIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary.	YES NO #yes, complete Items 9, 9a, and 9d.  13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the understigned physician or supplier for
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	services described below
SIGNED DATE // 1/0 9  14 DATE OF CURRENT ILLUSSS, INJURY, OF PREGNANCY (LMF) 15 OTHER DATE	SIGNED 10 N 31 0 N A 16 DATES PATIENT UNABLE TO WORK IN CURRENT COCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 173	FROM 67 65 2614 TO 5 08 2625
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	FROM (14 2 2007 TO (14 12 2030 20 CUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	YES TO OOO
A E 00-E90 B C	22 RESUBMISSION CRIGINAL REF. NO
	23 PRICE AUTHORIZATION NUMBER
24. A DATE(S) OF SERVICE B C D PROCEDURES, SERVICES, CR SUPPLIES E. From To RACEOF (Explain Unusual Orcumstances) DIAGNOSIS MM DD YY MM DD YY SERVICE EMG CPT/HCPCS   MODIFIER POINTER	F G H I D RENDERING CO PROVIDER ID. €
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25 FEDERAL TAX ID NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT? LGG Ku T LGG Ku T NO.	28 TOTAL CHARGE 29. AMOUNT PAID 30 Royd for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES CR CREDENTIALS If continuing the statements on the reserved.	33 BILLING PROVIDER INFO & PH# (CS2) 25 4 3 7 41
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S ATAIRST READ/RESS No. Seet)	2 PATIENT'S NAME (Last Name, F	irst Name, Middle Inital	)	MW DD	I YY -			ne, First Name, N	viddle Initial)	-10 76
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a EMPLOYMENT CONTROL OF PROJUCT CA GROUP NUMBER    DATION ACCORDENTY   PACE (Saling)		\ /		10 IS PATIENTS	S CONDITION RELI	NTED TO			/	
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E RESERVED FOR NUCCUSE  C OTHER ACCIDENTS    Yes   NO	o. RESERVED FOR NUCC USE				I LLI			Ł		
BISURANCE PLAN NAME OR PROGRAM NAME					-		in the second			
DISTRANCE PLAN NAME OR PROGRAM NAME   103 CLAIM CODES (Designated by NUCC)   0 IS THERE ANOTHER HEALTH BEJEFIT PLAN	HESERVED FOR NOCC USE			_		5		R FROGRAM N	AME	
12 PATIENTS CR AUTHORIZED PERSONS SIGNIFULES I authorized beneficial software from the information necessary by process this claim. I also request payment of government tenefits of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the information of the prity who accepts assignment tenefits of the	d INSURANCE PLAN NAME OF P	ROGRAM NAME	V 1000	10d CLAIM CCC	ES (Designated by	NUCC)	d IS THERE ANOTHER HEALT	H BENEFIT PLA	V12	- 17070
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14 OATE OF CURRENT ILLURES, INJURY, or PREGNANCY (LMP)   15 OTHER DATE   16 DATE   17 OATE   17 OATE   17 OATE   18 OATE   1	12 PATIENT'S CR AUTHORIZED F to process this claim. Laiso reque	PERSON'S SIGNATURE	Ell authorize their	elease of any med	ical or other informati		payment of medical benefits			
6   03   19	SIGNED Jennifer Wertz			DATE	8/21/19		SIGNED Jennifer We	rtz		,,
17   NAME OF REFERRINGS PROMDER OR OTHER SOURCE   174   175   17	MM I DD I YY	1 -			MM DD	YY		<u> </u>	1444	The second second
9 ADDITIONAL CLAMINFORMATION (Designated by NUCC)  20 OUTSIDELAB? SCHARGES  VES NO 0000  21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Plate At loss woeline below Q4D (CD Ind E00-E90)  8 C C D C COE  F G H CASH COLOR OF A DESIGNATION INVERSED OF STRUCK OF SUPPLIES (CRISHAL REF NO COE  12 5 99 02 08 00 11 55 99213 21 75 00 NPI 1245319599  12 5 99 02 08 00 11 55 99213 21 75 00 NPI 1245319599  12 5 FEDERAL TAX 1 D NUMBER SN EN SN EN SANSSANCES, OR SUPPLIES (CRISHAL REF NO COE  10 A DATE(S) OF SERVICE (CRISHAL REF NO COE  11 A DATE(S) OF SERVICE (CRISHAL REF NO COE  12 5 99 02 08 00 11 55 99213 21 75 00 NPI 1245319599  12 5 FEDERAL TAX 1 D NUMBER SN EN SN EN SR EN SERVICES (CRISHAL REF NO COE  12 5 99 02 08 00 11 55 99213 21 75 00 NPI 1245319599  13 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDITIALS (CRISHAL REF NO COE  14			200	+			MM DD Y	/Y	MM DD	YY
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25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? 28 TOTAL CHARGE 29 AMOUNT PAID 30 RSvd for NUCC US 883-67-9700 5348560988	From To	PLACE OF	(E≭pla	in Unusual Circum	istances)	DIAGNOSIS	DAYS	MPSDT	REND	ERING
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SCHED MIR H - O O E DATE 9 . To poin : page 117 - O O Prograd b	31 SIGNATURE OF PHY SICIAN C INCLUDING DEGREES OR OR (Loer life that the statements on apply to this bill and are made a	PR SUPPLIER SEDENTIALS The reverse a part thereof)	32 SERVICE FA 827 Jefferson ( Davenport, IA :	CILITY LCCATIO Ct 52802	NINFORMATION		33 BILLING PROMDER INFO- 20202 Washington Rd Bettendorf, IA 52722	S PH# (563		



PICA	EE (NOCC) USA'S	PICA ITTO
MEDICARE MEDICAID TRICARE      (Medicards) (Medicards) (IDS/DoDs)	CHAMPVA GROUP FECA OT HEALTH PLAN BLK LUNG (ID#) (ID#) (ID#)	HER 1a, INSURED'S LD NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Init	(a) 3 PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
Wertz Jenniter L 5 PATIENT'S ADDRESS (No., STEEL)	OB 35 97 M F C	X West z Jewifer, L 7 INSURED'S ADDRESS (No., Steet)
807 Wisconsin Stre	Self Spouse Child Other	807 Wisconsin Street
LeClaire	STATE 8. RESERVED FOR NUCC USE	LeClaire 1A
52753 (563 A89	15066 15066	21P CODE TELEPHCTIE (Include Area Code) 52753 (563) 2895066
9. OTHER INSURED'S NAME (Last Name, First Name, N		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BRITH SEX
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (SE	a INSURED'S DATE OF BRITH  08 M
C. RESERVED FOR NUCC USE	YES XNO	
C. NESENVED POR NOCCOSE	C. OTHER ACCIDENT?  VES NO	C. INSURANCE PLAN NAME OR PROGRAM NAME  On them  I IS THERE ANOTHER DEALTH PENERT OF ANG
d INSURANCE PLAN NAVE OR PROGRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES X NO #yes, complete items 9, 9a, and 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATUL	DRE COMPLETING A SIGNING THIS FORM. RE I authorize the refease of any medical or other information necessar	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
below  signer Jenniter Weetz	nent benefits either to myself or to the party who accepts assignment	services described below
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNA		IS DATES PATIENT UNABLE TO WORK IN CURRENT COCUPATION
6 03 19 OJAL GOOD	OUAL MM DD YY URCE 17a	FROM 04 15 19 TO 12 12 19
DR. Kevin Danie	17b NPI	FROM 04 15 19 TO 04 20 19
19 ADDITIONAL CLAIM INFORMATION (Designated by	NUCC)	20 OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Relate A-L to service line below (24E) ICD Ind	22 RESUBMISSION CRIGINAL REF NO
E.L. F.L.	_ CL DL	23 PRIOR AUTHORIZATION NUMBER
1	C. D. PROCEDURES, SERVICES, CR SUPPLIES E.	F. G. H. I. J.
MM DD YY MM DD YY SERVICE E	(Explain Unusual Oroumstances) DIAGNO EMG CPT/HCPCS   MODIFIER POINTI	
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		NPI
		751 00 NPI 1245319599 C
		NP)
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		NPI RPI
883-67-9700 SSN EN	26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT SEE BACK! YES NO	17 29 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use s 7, 24
31 SIGNATURE OF PHYSICIAN OR SUPPLIES	20 CERUICE CACILITY LOCATION INFOCALIATION	33 BILLING PROMDER INFORPH (563 5988745 20202 Washing Is N Rd Bettendorf, 1A 52122
(I certify that the statements on the reverse apply to this toll and are made a part thereof)	827 Jefferson Ct Davenpert, IA 52802	Re-Honderf IAS = 0
	Dan en part	Dollard, in Sanna
SIGNED TO THE OLD THE DATE OF	a NOL a	Bell allers, in 52122



1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN BLKLUNG (For Program in Nem 1)  X (Medicare#) (Medicard#) (Medicard#) (ID#/DcD#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)  3 PATIENT'S BIRTH DATE SEX  4 INSURED'S NAME (Last Name, First Name, Middle Initial)
Wertz, Jennifer, L 08 25 97 M FX Wertz, Jennifer, L
807 Wisconsh Street  6. PATIENT'S ADDRESS (No., Szeet)  7. INSURED'S ADDRESS (No., Szeet)  807 Wisconsin Street
STATE 8 RESERVED FOR NUCC USE CITY STATE
Le Claire IA  ZIP CODE TELEPHONE (Include Area Code)  Le Claire IA  ZIP CODE TELEPHONE (Include Area Code)
52753 (563) 289 5066 52753 (563) 289 5066
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 POUCY OR GROUP NUMBER a EMPLOYMENT? (Current or Previous)  a INSURED'S DATE OF BIRTH SEX
YES NO ON 1 P X
b RESERVED FOR NUCC USE  b AUTO ACCIDENT?  PLACE (State)  b OTHER CLAIM ID (Designated by NUCC)
YES X NO L CHESTANCE PLAN NAME OR PROGRAM NAME  C OTHER ACCIDENT?  C INSURANCE PLAN NAME OR PROGRAM NAME
XYES NO An them
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 A SIGNNO THIS FORM. 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Tauthorize the release of any medical or other information necessary to process his claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Jennifer Wertz DATE 8/21/19 SIGNED Jennifer Wertz
14 DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15 OTHER DATE MM   DD   YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Dr. Keum Daniels 170 NPI FROM DY 15 19 TO THE 120 19
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. CUTSIDE LAB? \$ CHARGES
21. DIÁGNIČŠIŠ CR NATURE OF ILLNESS CR INJURY Relate AL to service line below (24E) 100 legt 22. RESUBMISSION
A LEOD - E90 B C CODE CODE CODE
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I.
From To PLACEOF (Exchain Unusual Circumstances) DIAGNOSIS DAYS SERVICE EMG CPT/HCPCS MODIFIER POINTER \$ CHARGES UNITS FAIR QUAL PROVIDER ID. #
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25 FEDERALTAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO. 27, ACCEPT A SSIGNMENT? 28 TOTAL CHARGE 29 AMOUNT PAID 30 RSvd for NUCC U
883-67-9700 5348560988 X YES NO \$ 566.97 \$ 7.24
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (563) 5988745
(Certify that the statements on the reverse a post thereof)  827 Jefferson Ct  Davenport, IA 52802  20202 Washington R8  Davenport, IA 52722
Dovemport, IA 52802  Bottendorf, IA 52722
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I. MEDICARE MEDICA  (Medicarea) (Medicarea		CHAMPVI (Member/D	HEALTI	H PLAN THE CA	JNG OTHER	1a. INSURED'S I.D. NO. 241370DB3	JMBER		(For Program	ninibem 1)
2 PATIENT'S NAME (Last Nam	· · · · · · · · ·		3. PATIENT'S		SEX	4. INSURED'S NAME (	(Last Name,	First Name,	Middle Initial)	
Aguilar, Mario, A	4		3   9	)   86		Aguilar, Mari				
PATIENT'S ADDRESS (No.) 123 Sunny St	Street)		6. PATIENT RE	ELATIONSHIP TO IT	SURED	7. INSURED'S ADDRE		reet)		
CITY		STATE		FOR NUCC USE	Ome	CITY				STATE
St. Louis		Мо				St. Louis				MO
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	_		I AOIO AOG	YES X	PLACE (State)	b. OTHER CLAIM ID (I	Designated	by NUCC)		
RESERVED FOR NUCCUS	Ę		c. OTHER ACC	CIDENT?	L	c. INSURANCE PLAN	NAME OR F	PROGRAM N	AME	
			<u> </u>		40					
Anthem	R PROGRAM NAME		IC3	DDES (Designated b	y NUCC)	d. IS THERE ANOTHE			AN? e Items 9, 9a,	and Ord
REA	D BACK OF FORM BEFO	RE COMPLETING	A SIGNING TH	IS FORM.		13. INSURED'S OR AU		·		
<ol> <li>PATIENT'S OR AUTHORIZE to process this claim. I also re- tered.</li> </ol>						payment of medical services described		the undersign	ied physician (	or supplier for
below				. 09/27/2019	)					
SIGNED	SS. INJURY, or PREGNA	NCY (LMP) 15	DATE			SIGNED	INABLE TO	WORK IN C	UBBENT CCC	LIPATION
	QUAL	QU.	The second second	MM DD	YY	16 DATES PATIENT L	19	то		19
7. NAME OF REFERRING PR	OVIDER OF OTHER SOL					18. HOSPITALIZATION	)   47		CURRENT SE	T YY
Primary Care 9. ADDITIONAL CLAIMINFOR	BMATION (Designated by		NPI			FROM 6 3	19	07	6 10	19
		,				YES X	NO	<b>\$</b> 0.		
I. DIAGNOSIS OR NATURE (	OF ILLNESS OR INJURY	Relate A-L to serve	ce line below (24	4E) ICD Ind.		22 RESUBMISSION CODE		CRIGINAL R	————— ≢. NO	
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	F. L	. GŁ		н <u></u> _		23. PRICH AUTHORIZ	ATION NOR	VIDG H		
4. A DATE(S) OF SERV				CES, OR SUPPLIES		E.	G. DAYS E	H. I		J.
From VIM DD YY MIN	DD YY SERVICE E		in Unusual Circu CS	MODIFIER	POINTER	\$ CHARGES	OR I	Rattely ID. Plan QUAL		NDERING VIDER ID. #
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IT SIGNATURE OF PHYSICIA INCLUDING DEGREES OF (I certify that the statements apply to this bill and are ma	CREDENTIALS on hereverse	32 SERVICE FA	CILITY LOCATIO	ON INFORMATION		33 BILLING PROVIDE	HINFO& F	H# (	)	
	0/10/10						,,,,,			
SIGNED	9/10/19 DATE	a	b.	A		a	b.			



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MEDICARE MEDICAI  (Medicares) (Medicald)		CHAMPVA (Mamber (D)	- HEALTH PL	AN BEKLUNG	OTHER	1a INSURED'S I D NUM IEG4-TE5-MK		(For Pr	Ogram in Hem 1)
2. PAT ENT'S NAME (Last Name		السيا	(IDA) 3 PATIENT'S BIRTI	H DATE S	EX	4 INSURED'S NAME (La		lame. Middle Inl	hal)
Adams, John			10 30	1935 м⊠	F	Adams, John	,		,
5 PATIENT'S ADDRESS (No., S	teet)		6 PATIENT RELATI		RED	7 INSURED'S ADDRESS			
141 Franklin St		ler ere	Self X Spouse		Other	141 Franklin S	ı		
Quincy		MA	B RESERVED FOR	THUCCUSE		Quincy			STATE
ZIP CODE	TELEPHONE (Include Are					ZIP CODE	TELEF	PHONE (Include	
02169	(617) 770-117	75				02169	(	617 ) 770	-1175
OTHER INSURED'S NAME (L	ast Name, First Name, Midd	le initial)	ID IS PATIENT'S O	ONDITION RELAT	ED TO:	11 INSURED'S POLICY	GROUP OR FE	CA NUMBER	
a OTHER INSURED'S POLICY	OR GROUP NUMBER		a EMPLOYMENT?	(Outrent or Previou	ıs)	a INSURED'S DATE OF	RIDTU	111	SEX
				es X NO	,	a INSURED'S DATE OF MM   DD	1935	мХ	F
B RESERVED FOR NUCC USE			B AUTO ACCIDENT	7.0	LACE (State)	b. OTHER CLAIM ID (De		-	
				ES X NO					
C RESERVED FOR NUCC USE			C. OTHER ACCIDE!			c. INSURANCE PLAN NA Medicare	ME CR PROGR	RAM NAME	
d. INSURANCE PLAN NAME OF	R PROGRAM NAME		10d CLAIM CODES		UCCI	d IS THERE ANOTHER	HEALTH BENEF	T PLAN?	
Medicare						YES X NO	10%	omplete items 9	, 9a, and 9d
REAC 12 PATIENTS OR AUTHORIZE	BACK OF FORM BEFORE D PERSON'S SIGNATURE	COMPLETING authorize the re	A SIGNING THIS FO	DRM. or other information	n necessary	13 INSURED'S OR AUTH payment of medical bo			
to process this claim. It also re- below	quest payment of government	tenetits other to	myself or to the part	y who accepts assi	gnment	services described bel		eraightea physi	day or suppler to
SIGNED			DATE 9-	27-2019		SIGNED			
14 DATE OF CURRENT ILLNE	SS, INJURY, or PREGNANC	Y (LMP) 15 O	THER DATE	NIM	NAME OF TAXABLE PARTY.	16 DATES PATIENT UN	ABLE TO WORK	(IN CURRENT	OCCUPATION
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7 NAME OF REFERRING PRO	OVIDER CRIOTHER SOURC	1				18 HOSPITALIZATION D	ATES RELATES	MM	T SERVICES DD YY
19 ADDITIONAL CLAIM INFOR	MATION (Designated by NU	t7h	NPI			PROM 20 OUTSIDE LAB?		TO SCHARGES	
						YES N	0	1	
21 DIAGNOSIS OR NATURE C	FILLNESS CR INJURY Ref	late A-L to survio	e line below (24E)	ICD Ind		22 RESUBMISSION CODE	CBIGIS	IAL REF NO.	
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E L	F L	a∟		н І		23 PRICE AUTHORIZAT	ION NUMBER		
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25 FEDERALTAX ID NUMBE	A SSNEW 2	6 PATIENT'S AC	COUNTRIO	27 ACCEPT 400	GNIMENTO	28 TOTAL CHARGE		NPI C	30 Raud for NUCCUs
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31 SIGNATURE OF PHYSICIAL	OR SUPPLIER 3	2 SERVICE FAC	CILITY LOCATION IN		1.10	33 BILLING PROVIDER	100 100 100	( )	
(I certify that the statements)	on the reverse		General Hospital						
apply to this bill and are mad	· 1	5 Fruit St Joston, MA 021	114						
	а		h.		-	a NEI	b.		
SIGNED	DATE	DATE	Transa			- N. T	М.		



PICA											PICA [
1. MEDICARE MEDICAL		CHAMPV.	- HEAL	UP .TH PLAN	- BECA	3	ta INSUREDIS I.D			(For Progra	am In Hem 1)
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Roberts, Hermione		•1	MM-1   E	81 82	м	F X	Weasley, F		e, Frativalie,	Neddie Tatal,	,
5. PATIENT'S ADDRESS (No , S	Steet)		6 PATIENT		HIP TO INSU		7. INSURED'S ADD	RESS (No., S	Street)		
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London		STATE	8 AESEAVE	D FOR NUC	CUSE		London				STATE
ZIP CODE	TELEPHONE (Include A						ZIP CODE	<u> </u>	TTELEPHON	E (Include Are	
63011	(314) 123-87	764					63011		1	987-4	
9. OTHER INSURED'S NAME (L	/		10 IS PATIE	NT'S CONDI	TION RELAT	TED TO:	11. INSURED'S PO		,		
Potter, Ginny J							W4984016				
a. OTHER INSURED'S POLICY	OR GROUP NUMBER		a, EMPLOYN			us)	a. INSURED'S DAT MM ; D	E OF BIRTH		SEX	
b RESERVED FOR NUCC USE			b. AUTO AC	YES CIDENT?	X NO		08   13			X	F
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d INSURANCE PLAN NAME OF	R PROGRAM NAME		10d. CLAIM (	CCDES (Des	gnated by N	UCC)	d. IS THERE ANOT	HER HEALTH	H BENEFIT PI	AN?	
	HANGE FOR THE	T 501101	4 8881111				YES	<del></del>	If yes, comple		
12 PATIENT'S CR AUTHORIZE		El authorize the i	elease of any r	nedical or oth			13 INSURED'S OF payment of med	ical benefits to			
to process this claim. I also re below	quest payment or governme	nt cenetits amer	no, myselfor no, t	ne party who	accepts ass:	gnment	services describ	ed below			
SIGNED			DA	TE			SIGNED				
14. DATE OF CURRENT ILLNE:	SS, INJURY, or PREGNAN	ICY (LMP) 15.	OTHER DATE	ММ	ı DD ı	YY	16. DATES PATIEN	T UNABLE J	O WORK IN C	URRENT CO	CUPATION
08 31 2019	DUAL	Qυ	AL				FROM 08	31   201	9 10	10 31	2019
17, NAME OF REFERRING PRO	OVIDER OR OTHER SOUR						18 HOSPITALIZAT	יץ , סס	Y	MM DI	⊃ <sub>i</sub> YY
19. ADDITIONAL CLAIM INFOR	MATION (Designated by N		NP)				FROM 08	31 201		09 02	2 2014
		,					YES	□ NO I	40	nances	
21. DIAGNOSIS OR NATURE C	FILLNESS CA INJURY A	Relate AL to serv	ce line below (	24E)  CE	) Ind		22 RESUBMISSIO		COLCUMA D	<u> </u>	<u> </u>
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MM   DD   YV   MM   DD   YV   FROM   15   2010   TO 12   30   17	SGNED	DATE	SIGNED
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