HEALTH INSURANCE CLAIM FORM

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

PICA　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　PICA

CARRIER

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): 65539787
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Tyler, Liv	3. PATIENT'S BIRTH DATE MM DD YY: 09 30 90 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Tyler, Steven	
5. PATIENT'S ADDRESS (No., Street): 104678 Vine	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 3218 5th Ave	
CITY: Hollywood — STATE: CA	8. RESERVED FOR NUCC USE
CITY: New York — STATE: NY	
ZIP CODE: 54376 — TELEPHONE (Include Area Code): (212) 5544444	ZIP CODE: 01234 — TELEPHONE (Include Area Code): (212) 5554444
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: 4536426	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 06 06 56 — SEX M [X] F [ ]	
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: myhealthplan	
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 ______________________ 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 ______________________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 01 19 QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. k35.3 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	01	19	07	23	19									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 $ 123498.54	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

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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson, Roberto A

3. PATIENT'S BIRTH DATE: MM 02 DD 22 YY 80 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Williamson, Sarah B

5. PATIENT'S ADDRESS (No., Street): 15 Alpha St

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

7. INSURED'S ADDRESS (No., Street): 97 Lane Drive

CITY: Ozark | STATE: Mo

8. RESERVED FOR NUCC USE: this is sparta

CITY: Ladue | STATE: MO

ZIP CODE: 62405 | TELEPHONE (Include Area Code): (721) 2122234

ZIP CODE: 42411 | TELEPHONE (Include Area Code): (242) 2242432

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: AI1I1I1I1IALIAI17I

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

a. INSURED'S DATE OF BIRTH: MM 02 DD 42 YY 80 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE: NOT RESERVED

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

b. OTHER CLAIM ID (Designated by NUCC): NA

c. RESERVED FOR NUCC USE: THINGS

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: 7 hearts

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC): 4562L52

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 _____ DATE 09/23/19

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 no

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 02 12 1980 TO 02 15 80

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: John Doe

17a.

17b. NPI 0794234

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): this is hurting

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES 42.42

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

A. beta B. sigma C. D.

E. zeta F. alpha G. H.

I. iota J. K. L.

22. RESUBMISSION CODE: ABC ORIGINAL REF. NO: 4219

23. PRIOR AUTHORIZATION NUMBER: 42067257

PHYSICIAN OR SUPPLIER INFORMATION

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 24 23	06 10 42	NJ		452	2	A	9999 99	2		NPI	42156
2	8 85 14	02 00 12	MO		c904	5 7	B	500 14	1		NPI	67345
3	15 27 6	5 02 56	AL		1568	4	C	20 13	4		NPI	22221
4	99 12 14	4 01 75	MO		2567	A	D	1 34	5		NPI	47800
5	02 15 78	56 21 82	IL		1342	B	E	717 77	6		NPI	56201
6	02 11 11	44 42 41	NJ		2541	6	F	2000 00	7		NPI	888888

25. FEDERAL TAX I.D. NUMBER SSN EIN: 8x447529252

26. PATIENT'S ACCOUNT NO: 07250006

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

28. TOTAL CHARGE $ 14463 42

29. AMOUNT PAID $ 500 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

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

HEALTH INSURANCE CLAIM FORM

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

PICA

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): 8675309

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hamilton, Lewis

3. PATIENT'S BIRTH DATE: MM 01 DD 07 YY 85 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1600 pennsylvania Ave NW

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

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

CITY: Washington | STATE: D.

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include 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:

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 [ ] 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: Keal Good Insurance Plan

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 _____ DATE 9/27/18

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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 09 DD 24 YY 18 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

HEALTH INSURANCE CLAIM FORM

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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): 15372892S

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

3. PATIENT'S BIRTH DATE MM DD YY: 09 31 86 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Jones, Blake, R

5. PATIENT'S ADDRESS (No., Street): 47 Rue De Grand

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

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

CITY: 63367

STATE: M

8. RESERVED FOR NUCC USE

CITY:

STATE:

ZIP CODE:

TELEPHONE (Include Area Code): ( )

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) [X] YES [ ] NO

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

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

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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 _____ 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										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

HEALTH INSURANCE CLAIM FORM

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

PICA

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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): 0000010

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Martha X Dan

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 2001 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): martha X dan

5. PATIENT'S ADDRESS (No., Street): 1 City Place, St Louis 63021

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

7. INSURED'S ADDRESS (No., Street): 1 City Place, St louis 63021

CITY: St louis STATE:

8. RESERVED FOR NUCC USE

CITY: St Louis STATE:

ZIP CODE: 63021 TELEPHONE (Include Area Code): (800) 800-8000

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 62A7

a. OTHER INSURED'S POLICY OR GROUP NUMBER: X12141

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? [X] YES [ ] 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 _____ DATE Sep 2 2019

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: 09 11 2018 QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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.

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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): 879777815

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wozzer, Erik, C

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 1955 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Wozzer, Sammy, R

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet Dr.

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

7. INSURED'S ADDRESS (No., Street): 123 Anystreet Dr.

CITY: Gotham | STATE: AR

8. RESERVED FOR NUCC USE

CITY: Gotham | STATE: AR

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (604) 175-2649

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 7256125

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) [X] YES [ ] NO

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

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

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: AR761MNZ34

a. INSURED'S DATE OF BIRTH MM DD YY: 15 20 1901 | SEX M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: Great Plans

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) MM DD YY: 12 13 2019 QUAL -

15. OTHER DATE QUAL [ ] MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 9 27 2019 TO 05 27 2050

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Anoter Person

17a [ ]

17b. NPI [ ]

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 2500.00

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: 12687 ORIGINAL REF. NO.: 4

23. PRIOR AUTHORIZATION NUMBER: 12FB789

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: 842-768-32 [X]

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): 13371337

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

3 PATIENT'S BIRTH DATE: 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: Hadseb | 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) 0987654

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: 123123123

a OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a INSURED'S DATE OF BIRTH: 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 _____ 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

PHYSICIAN OR SUPPLIER INFORMATION

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

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): 23411

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Alex Friday

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 2001 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1 Road

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

7. INSURED'S ADDRESS (No., Street): 1 Road

CITY: Coxtown STATE: FL

8. RESERVED FOR NUCC USE

CITY: Coxtown STATE: FL

ZIP CODE: 6000 TELEPHONE (Include Area Code): (414) 515 6161

ZIP CODE: 6000 TELEPHONE (Include Area Code): (414) 515 6161

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) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 01 01 2001 SEX M [ ] F [X]

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? [ ] 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 [ ] 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 09/26/2019

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Radish, Josie, K

3 PATIENT'S BIRTH DATE MM DD YY: 9 17 1989 SEX M [ ] F [X]

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

5 PATIENT'S ADDRESS (No., Street): 1117 Cleveland Ave

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

7 INSURED'S ADDRESS (No., Street): 1100 Michigan Ave

CITY: kirkwood STATE: mo

8 RESERVED FOR NUCC USE

CITY: Purchase STATE: NY

ZIP CODE: 63122 TELEPHONE (Include Area Code): (314) 800-8766

ZIP CODE TELEPHONE (Include Area Code): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Miller, Nancy M

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER

a OTHER INSURED'S POLICY OR GROUP NUMBER: GM01761A

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

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): MI

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: Sunshine Health

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 _____ DATE 9/18/19

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 _____

PATIENT AND INSURED INFORMATION

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 3 4 19	4 5 18			ASK			750 99			NPI	1740985321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

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

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (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): 23435O23

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Jones, 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): (213) 555-1145

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

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: 123454567

a. INSURED'S DATE OF BIRTH MM DD YY: 03 19 7O SEX M [ ] F [X]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: MyHomestate 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: 01 02 19 QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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	o1	o2	I9	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