

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 MEDICAID TRICARE OTHER 1a INSURED'S I D. NUMBER (For Program In Hem 1) (Medicare#) ast Name, First Name, Middle Inital) RED'S NAME (Last Name, First Name, Middle Initial) 6 PATIENT RELATIONSHIP TO INSURED Spouse] child STATE 8 RESERVED FOR NUCC USE INFORMATION TELEPHONE (Include Area Code) 121172239 10. IS PATIENT'S CONDITION RELATED PATIENT AND INSURED a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH YES C. OTHER ACCIDENT? gnated by NUCC) LTH BENEFIT PLAN? NO 13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the understaned physician or supplier for to process this c below 15 OTHER DATE QUAL 17a FROM то 20 OUTSIDE LAB? \$ CHARGES ICD Ind D H^{-1} PROCEDURES, SERVICES, CR SUPPLIES (Explain Unusual Oroumstances)
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1. MEDICARE MEDICAID TRICARE CHAN (Medicares) (Medicalds) (IDS/DoDs) (Memi	- HEALTH PLAN - BLK LUNG -	1 1a. INSURED'S I D. NUMBER (For Program in Hem 1)
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12345 (604) 175-2649		12345 (555)7256/25
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
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READ BACK OF FORM BEFORE COMPLET 12 PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize	the release of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefit a below	to myself or to the party who accepts assignment	services described betaw.
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	15. OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
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21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY Relate A-L to s	er woe line below (24E) ICD Incl	22. RESUBMISSION CRIGINAL REF. NO.
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t. L. J. L.	<u> </u>	12-8 707
	DOEDURES, SERVICES, OR SUPPLIES E. xplain Unusual Circumstances) DIAGNOSIS	F. G. H. I. DAYS EPSOT ID. RENDERING CR. Farmy S.CHARGES UNITS Fan QUAL PROVIDER ID. #
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842-768-32 X	YES NO	\$ \$
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE	FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH . ()
(I certify that the statements on the reverse		
apply to this bit and are made a part thereof)		
SIGNED DATE a	ABL P	a.
Vi ICC Instruction Manual available at www.nucc.org	DI EACE DOINT AD TYDE	APPRIMED CMRUGGR, 1107 FCRM, 1500 (02.1



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1. MEDICARE MEDICAID TRICARE CHAMPV	- HEALTH PLAN - BLK LUNG -	1a. INSURED'S I.D. NUMBER	(For Program in Illem 1)	
X (Medicares) (Medicards) (IDS/DoDs) (Member II	$(10s) \qquad (10s) \qquad (10s)$	241370 PB3		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name	, First Name, Middle Initial)	
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5. PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., S	reel)	
1,23 Sunny St	Self Spouse Ohlid Other	123 Junny	St	
	B RESERVED FOR NUCC USE	CITY	STATE	
St. Lowis Mo		St. Lowis	Mo	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)	
63098 (314) 123-0101			(314) 123 - 0101	
7, 7		63.088	1	
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	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX	
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RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated	by NUCC)	
	YES NO			
RESERVED FOR NUCCUSE	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR	FROGRAM NAME	
	YES NO			
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	d IS THERE ANOTHER HEALTH	BENEFIT PLAN?	
Anthem	163		Vives, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING			D PERSON'S SIGNATURE I authorize	
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the r	release of any medical or other information necessary	payment of medical benefits to	o the undersigned physician or supplier for	
to process this claim. I also request payment of government benefits either below.	to mysell or to the porty who accepts assignment	services described below.		
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7. NAME OF REFERRING PROVIDER CR OTHER SOURCE 173		18. HOSPITALIZATION DATES R	ELATED TO CURRENT SERVICES	
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9 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$CHARGES	
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INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse			3	
apply to this bill and are made a part thereof.)				
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JCC Instruction Manual available at www.nucc.org	The second secon			
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1. MEDICARE MEDICAID TRICARE CHAMPV (Medicare#) (Medicard#) (ID#/DoD#) (Member II	HEALTH PLAN BLK LUNG	1a INSURED'S LO NUMBER (For P	rogram in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE SEX	1 EG4- TE5-MK 4 INSURED'S NAME (Last Name, First Name, Middle In	nit al)
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141 Franklin St	6. PATIENT RELATIONSH:P TO INSURED Self Spouse Child Cities	141 Franklin St	
QUINCY STATE	B RESERVED FOR NUCC USE	сту	STATE
ZIP CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Indude	MA e Area Code)
02169 617)770-1175			70-1175
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)	a INSURED'S DATE OF BIRTH	SEX
b. RESERVED FOR NUCC USE	D AUTO ACCIDENT?	b. OTHER CLAIM ID (Designated by NUCC)	F
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d INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. CLAIM CCDES (Designated by NUCC)	MECLICATE d ISTHERE ANOTHER HEALTH BENEFIT PLAN?	
Medicare		YES NO II yes, complete items 9	9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S CR AUTHCRIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request as yment of government benefits other	elease of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATI payment of medical benefits to the undersigned physiserwices described below.	
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a		18 HOSPITALIZATION DATES RELATED TO CURREN	T SERVICES DD YY
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INCLUDING DEGREES OF CREDENTIALS (I certify that the statements on the reverse) MQ654	chusetts General Hospital	S. S	
apply to this bill and are made a part hereo!)	it st MA OZIIY		
SIGNED DATE a.	b	a NPI b	
NUCC instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED CMB-0908-1197 Fo	CRM 1500 (02-12)



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2 PATIEUT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, East Name, Middle Inlia	al)
5 PATIENT'S ADDRESS (No., Steet)	6. PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No. Street)	1
1 Road	Selfa Spouse Child Other	1 Road	0
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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	
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c. RESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OF PROGRAM NAME	
	YES NO	C. INCORPRES FERRI HAVIS OF FROGRAM NAVE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d ISTHERE ANOTHER HEALTH BENEFIT PLAN?	
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READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S CR AUTHORIZED PERSON'S SIGNATURE I authorize the	release of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S SIGNATUR payment of medical benefits to the undersigned physicial 	
to process this claim. I also request payment of government benefits either below	to myself or to the party who accepts assignment	services described below.	
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I MM (DD) YY () ()	OTHER DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT C	CCUPATION DD 1 YY
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19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
		YES NO	
21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	ice line below (24E) ICD Ind	22. RESUBMISSION CRIGINAL REF. NO.	
B.L. C.L.	D.	23. PRIOR AUTHORIZATION NUMBER	
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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 Use
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31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FA INCLUDING DEGREES OR CREDENTIALS	ACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH# ()	
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1 MEDICARE MEDICAID TRICARE CHAMPV.	HEALTH PLAN BLK LUNG	1a. INSURED'S 1 D. NUMBER (For Program in Item 1)
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2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	9 PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
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5 PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No. Street)
1234 Med Space	Self Spouse Child Other	s are as futitits
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St. Louis Mo		1, ''
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63117 (351) 155 -7212		()()() [
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
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d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
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12 PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the	elease of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.	to myself or to the porty who accepts assignment	services described below
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17, NAME OF REFERRING PROVIDER OR OTHER SOURCE 174		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTFIDE LAB? \$ CHARGES
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E Plut FIFIU GL	Heart HL	23 PRICE AUTHORIZATION NUMBER
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NUCC Instruction Manual available at www.nucc.org	PLEASE PRINT OR TYPE	APPROVED CMB-0936-1197 FORM 1500 (02-12)



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t. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER	11 11 INSURED'S I D. NUMBER (For Program in Item 1)
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5. PATIENT'S ADDRESS (No., Steet) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Steet) 457 Bumur St.
CITY SELL Spouse Child Other STATE B RESERVED FOR NUCC USE	CITY I STANS:
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630() (3/4)123-8764	TELEPHONE (Include Area Code) (3/4) 987 - 4231
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 PROUP NUMBER a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
YES NO	a INSURED'S DATE OF BIRTH SEX O M X F
b RESERVED FOR NUCC USE b AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCCUSE c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR FROGRAM NAME
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d INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	d ISTHERE ANOTHER HEALTH BENEFIT PLAN? YES X NO // yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIDNING THIS FORM. 12 PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
to process this claim. I also request payment of government tenefits either to myself or to the party who accepts assignment below.	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNEDDATE	SIGNED NON Weasly
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OUAL MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
17b NPI	FROMOS 31 2014 1009 02 2014
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)	22. RESUBMISSION CODE CRIGINAL REF. NO.
A L C L D. L	23. PRICR AUTHORIZATION NUMBER
F. L. G. H. L.	
24. A. DATE(S) CF SERVICE B. C D. PROCEDURES, SERVICES, CR SUPPLIES E. From To RACEOF (Explain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. DAYS EPOTI ID. RENDERING OR Family SCHARGES UNITS Pan QUAL PROVIDER ID. #
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25 FEDERAL TAX LD NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	NPI NPI
25 FEDERAL TAX I D NUMBER SSN BN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? 12 46 8 10 9 YES NO	\$ VOSCO \$ SOC STORM SANDONT PAID 30 RSVd for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH # ()
() certify that the statements on the reverse apply to this bill and are made a part hereof.)	
SIGNED DATE a b. NUCC Instruction Manual available at www.nucc.org PLEASE PRINT OR TYPE	APPROVED CMB-0938-1197 FCRM 1500 (02-12



Adam Lenan

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 MEDICAID CHAMPVA CHAMPYA GROUP HEALTH PLAN BLKLUNG (ID#) (ID#) (ID#) (Medicales) (Medicalds) (IDS/DoDs) (IDA) Spouse STATE B RESERVED FOR NUCC USE CITY

apply to this bill and are made a par	(mereor)											
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ADDITIONAL CLAIM INFORMATIO	N (Designated by N	JCC)					20 CUTSIDE LAB?	ן מין	\$	CHARG	ES	
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SIGNED DATE OF CURRENT ILLNESS, INJ	URY, or PREGNAN	CY (LMP) 15.	OTHER DATE			- Alban	algned 16 DATES PATIENT	UNABLE 1	TO WORK IN	CURRE	NT OCCUP	ATION
to process this claim. I also reguest p below	ayrishtu guveninle	iii reiiAile albei			uvepis assign	ment	services described	t below				1000
PATIENT'S CR AUTHCRIZED PER	COF FORM BEFOR	🗄 l authorize the	release of any	medical or other	Intermation r	ecessary	13 INSURED'S OR A payment of medic.	al benefits	ED PERSON	SSIGN	ATURE I au I	horize
ISURANCE PLAN NAME OR PRO	3RAM NAME		10d CLAIM	CCDES (Desig	nated by NU	C()	d IS THERE ANOTHI	ER HEALT	H BENEFIT		s 9, 9a, and	19d
			C. OTHER	YES	NO		C. INSURANCE PLAN					
ESERVED FOR NUCCUSE			C. OTHER A	YES	□ NO [CC (State)						
ESERVED FOR NUCC USE			b AUTO AC	YES CODENT?	NO NO	CE (State)	b. OTHER CLAIM ID	(Designate		М	F	L
THER INSURED'S POLICY OR GR	ROUP NUMBER		a EMPLOY	MEHT? (Curren	or Previous		a INSURED S DATE	OF BIRTH	1		SEX	20
OTHER INSURED'S NAME (Last Na	me, First Name, Mic	tale Inilial)	10 IS PATIE	ENT'S CONDITI	ON RELATE	O TO	11. INSURED S POLI	CY GROU	PORFECA	NUMBER	1	
									1 1			



CARRIER TH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 8675309 CHAMPVA MEDICALD OTHER (For Frogram in Item 1) GROUP HEALTH PLAN (ID#) BEKLUNG (ID#) (Medicare#) (ID#/DoD#) (Medicald#) (Mamber IDII) ((0#) First Name, Middle Initial) PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SEX Lewis 85 MX tamilton 07 7. INSURED'S ADDRESS (No., Street) 1600 Self X Spouse Child Other STATE B RESERVED FOR NUCC USE CITY STATE PATIENT AND INSURED INFORMATION D.C. TELEPHONE (Indude Area Code) ZIP CODE TELEPHONE (Include Area Code) (134)-357-6666 20500 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) a. INSURED'S DATE OF BIRTH SEX YES F b RESERVED FOR NUCC USE b AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES NO c. RESERVED FOR NUCCUSE c. OTHER ACCIDENT? C. INSURANCE PLAN NAME OR FROGRAM NAME Kent YES 10d: CLAIM CODES (Designated by NUCC) d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO. Hyes, complete items 9, 9a, and 9d READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S CR 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. 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below 9127/18 SIGNED 16. DATES PATIENT UNABLE TO WORK IN CURRENT 15 OTHER DATE MM ĐĐ QUAL то 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17. NAME OF REFERRING PROVIDER 17a 17b NP FROM то 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES YES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate All to service line below (24E) 22. RESUBMISSION CODE ICD Ind CRIGINAL REF. NO. Ď. 23. PRICE AUTHORIZATION NUMBER Ε H24 PROCEDURES, SERVICES, OR SUPPLIES PHYSICIAN OR SUPPLIER INFORMATION From PLACE OF (Explain Unusual Circumstances)
OPT/HCPCS MODIFIE RENDERING To DIAGNOSIS ID MAA DD PROVIDER ID. # POINTER QUAL NPI NPI NPI NPI NPI NPI 25 FEDERALTAX ID NUMBER SSN EIN 28 TOTAL CHARGE 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For govt claims, see basi) 29 AMOUNT PAID 30 Rsvd for NUCC Use YES \$ 31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION 33 BILLING PROVIDER INFO & PH # INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.)

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SIGNED

PLEASE PRINT OR TYPE

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APPHOVED CMB-0936-1197 FORM 1500 (02-12



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA TTT
MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	ta INSURED'S I D NUMBER (For Program in Hem 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ft	0.8) (10.8) (10.8)	00000 10
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Marsha X Dan	PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle hiltal) Martha X Dan
5. PATIENT'S ADDRESS (No , Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INCHESTO ASSESSO (III. Drawn)
1 city place, \$5 louis 63021		1 city place, & louis 6302
CITY & Couis	8 RESERVED FOR NUCC USE	STATE STATE
ZIP CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Indude Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIBUT'S CONDITION RELATED TO	63021 (800) 800 - 8000
Dan Marsha		62A7
a OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Ourrent or Previous)	a. INSURED'S DATE OF BIRTH SEX
b RESERVED FOR NUCC USE	b AUTO ACCIDENT?	MF
	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c OTHER ACCIDENT?	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?
C. HOSTINGS I SAY HAVE OF FROGRAM HAME	Total CERTINI CODES (Designated by NUCC)	YES NO #yes, complete items 9, 9a, and 9d
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S CRI AUTHORIZED PERSON'S SIGNATURE I authorize the		13 INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. It also request payment of government benefits either below.		services described below
SIGNED (WWW)	DATE Sep 2 2019	SIGNED (WW
MM r DD r YY	OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT CCCUPATION
09 11 2018 CUAL CUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.		FROM TO TO 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	NP)	FROM TO YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OF NATURE OF ILLNESS OF INJURY Relate A-L to serv	ice line below (24E)	YES NO 22. RESUBMISSION
ALBLCL	ICD Ind	CODE CHIGINAL REF. NO.
E G L	н 🗀	23. PRIOR AUTHORIZATION NUMBER
	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
	in Unusual Circumstances) DIAGNOSIS	
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25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S /	(For gove claims, see pack)	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCCUSE
	CILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH ()
INCLUDING DEGREES OF CREDENTIALS (I certify that the statements on the reverse		, ,
apply to this bill and are made a part thereof.)		
SIGNED DATE a DI	b.	a NP b.
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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 82/12 PICA PICA PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER 1a INSURED'S I.D NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (ID#) (ID#) (ID#)
2 PATIENT'S NAME (Last Name, First Name, Mode Initial) 2. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Mode Initial) RAD 1.7 1989 M FX 4. INSURED'S NAME (Last Name, First Name, Mode Initial)
5. PATIENT'S ADDRESS (No., Seet.) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Steet.)
1117 Cleveland Ave seix spouse child other 1100 Michigan Hul
STATE B RESERVED FOR NUCC USE CITY STATE PUVCHOSE NO
VIV KWOOD TELEPHONE (Indude Area Code) ZIP CODE TELEPHONE (Indude Area Code)
63122 (314)800-87 lave 31021 ()
STATE WIVEWOOD TELEPHONE (Induce Area Code) 2P CODE TELEPHONE (Induce Area Code) 3 10 31 3 0
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX
COMO 1761A VES XIVO MM PD YY M F
b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
C. OTHER ACCIDENT? C. OTHER ACCIDENT? C. INSURANCE PLAN NAME CR PROGRAMINAME () ()
TYES FIND Sharpe Health
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO **** NO ***************************
12. PATIENT'S CRIAUTH CRIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary by processarily claim. I also request prymercy of overgrent tenefits other to myself or to the party why accepts as propert.
telow On it / On / O
SIGNED SIGNED SIGNED
14. DATE OF CURRENT ILLUTESS, VAURY, OF PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION OUAL FROM DD YY FROM DD YY TO MM DD YY
17. HAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 18 HOSPITATION DATES RELATED TO CURRENT SERVICES MM. DD YY
17b NPI FROM TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to ser voe line below (24E) ICD Ind 22. RESUBMISSION CRIGINAL REF. NO.
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E L G L H L 23. PRICE AUTHORIZATION NUMBER
1,
24. A DATE(S) OF SERVICE E. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. P. G. H. T. FEBT OR SUPPLIES E. FEBT OR SUPPLIE
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YES NO \$ \$ 31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION 33 BILLING PROVIDER INFO & PH # (
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(I certify that the statements on the reverse apply to this bill and are made a part inereof.)
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