

PICA	PICA TT	1
— HEALTH PLAN — BIKILING	ta, INSURED'S I D. NUMBER (For Program in Rem 1)	仗
(ID#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	0576444	П
MM DD YY	4 INSURED'S NAME (Last Name, First Name, Middle Initial)	
5 PATIENT SADDRESS (No. Steel) 6 PATIENT RELATIONSHIP TO INSURED	Finn, Merlin S 7 INSURED'S ADDRESS (No., Steet)	
42 Wallaby Way Sell Spouse Child Other	42 Wallaby Way	П
CITY STATE 8 RESERVED FOR NUCC USE	CITY STATE	Ľ
Stolney	sydney AL	PATIENT AND INSURED INFORMATION
ZIP CCDE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHOLE (Indude Area Code)	Į
59876 (231) 1234567	59076 (231) 1234567	200
9 OTHER INSURED'S NAME (Last Name, Rist Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER	烂
	RE 351414	
a OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX	E
D RESERVED FOR NUCC USE PAUTO ACCIDENTS	05 04 88 MX F	SN
PLACE (Sate)	b OTHER CLAIM ID (Designated by NUCC)	9
c. RESERVED FOR NUCCUSE c. OTHER ACCIDENT?		2
TYES THO	C INSURANCE PLAN NAME CR PROGRAM NAME	2
d INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CODES (Designated by NUCC)	Deep Sca Heath d is there unother health benefit plan?	E
7.55 C.S. 1.55 C	YES X NO If yes, complete items 9, 9a, and 9d	٩
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize	H
12 PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release of any modical or other information necessary to process fills claim. I also request payment of government benefits either to myself or to the party who accepts assignment.	payment of medical benefits to the undersigned in ysid an or supplier for services described below	
below.		П
SIGNED Nemo Finn DATE 05/17/8	SIGNED Meulin tinn	+
14 DATE OF CURRENT ILLNESS, INJURY OF PREGNANCY (LMP) 15 OTHER DATE MM DD YY MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT COCUPATION MM DD TYY	I
02 21 06 GIAL GOOD QUAL	FRCM 02 09 08 TO 02 15 10	T
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	
17h NPI 19 ADDITIONAL CLAIM INFORMATION (Durrated by NUCC)	FROM 02 28 12 TO 04 06 14	
19 ADDITIONAL CLAIM INFO-MIATION (IAC DIRIGIO BY NOCC)	20 CUTSIDE LAB? \$ CHARGES	Ш
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (245)	YES X NO O. OO	
1CO and	22 RESUBMISSION CRIGINAL REF NO	
R C D	23 PRICR AUTHORIZATION NUMBER	
EL		П
24 A DATE(S) OF SERVICE B C. D PROCEDURES, SERVICES, OR SUPPLIES E.	F G H I J	z
From To RACEOF (Explain Unusual Orgunistances) DIAGNOSIS MM DD YY MM DD YY SERVICE EMG OPT/HCPCS MODIFIER POINTER	\$ CHARGES UNITS RITE CUAL PROVIDER ID	2
	11.0013510	¥
12 5 99 02 08 00 11 55 9943 24	305. 8¢ NPI	CO
		ž
	NP	6
		五
	NPI NPI	3
		38.
	NPI NPI	Z
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	당
	I ARDI I	
	NP;	YS
		PHYSICIAN OR SUPPLIER INFORMATION
25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	NPI NPI 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use	- PHYSI
25 FEDERAL TAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT? 467-69-4578 X 357-634 X YES NO.	1 1351	PHYSI
487-89-4578 X 357-634 X YES NO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use \$ 215 2 .66° \$ 0 0 33 BILLING PROVIDER INFO 8 PH# (587) 4 5 7896 >	PHYSI
467-89-4578 X 357-634 X YES NO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE FACILITY LOCATION INFORMATION \$25 OCCUPY	28 TOTAL CHARGE 29 AMOUNT PAID 30 RSvd for NUCC Use \$ 215 2 66 \$ 0 0 33 BILLING PROVIDER INFO & PH# (587) 45 7896 2 712 Coval Pd	PHYSI
487-89-4578 X 357-634 X YES NO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE FACILITY LOCATION INFORMATION 23 SERVICE FACILITY LOCATION INFORMATION	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use \$ 215 2 .66° \$ 0 0 33 BILLING PROVIDER INFO 8 PH# (587) 4 5 7896 >	PHYSI
467-89-4578 X 357-634 X YES NO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE FACILITY LOCATION INFORMATION \$25 OCCUPY	28 TOTAL CHARGE 29 AMOUNT PAID 30 RSvd for NUCC Use \$ 215 2 66 \$ 0 0 33 BILLING PROVIDER INFO & PH# (587) 45 7896 2 712 Coval Pd	PHYS!



PICA	PICA
less en	A 1a INSURED'S LD NUMBER (For Brogram in Item 1)
(Medicale#) (Medicale#) (ID#/OcO#) (MemberID#) (ID#) (ID#)	3167c472 4 INSURED'S NAME (Last Name, First Name, Middle Initial)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX MM DD YY YY A STANDARD SEX	
Tholmes Phillip T 02 28 70 MX F 5. PATIENT'S ADDRESS (No., Szeet) 6. PATIENT RELATIONSHIP TO INSURED	Holms Phillip T 7. INSURED'S ADDRESS (No., Sfeet)
888 Straberry lane Sell Spouse Child Other	888 strawboung Lang
/ ISINIE 8. RESERVED FOR NOCC USE	CITY
Pho.'S Mo	Phris ZIP CODE (660) 800 SU 30 TELEPHCHE (Include Area Code) (660) 800 SU 30
65812 (640) 800 5430	ZIP CODE
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	(60) 800 S4 30
	6 657
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?	04 5 70 4
PLACE (Sate)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCCUSE c. OTHER ACCIDENT?	
YES NO	C INSURANCE PLAN NAME OR PROGRAM NAME RIVE COSS GIOTURE ANOTHER MANAGEMENT BLANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	d is there another neath benefit PLAN?
READ BACK OF FORM BEFORE COMPLETING A SIGNING THIS FORM.	YES 1 NO #yes, complete Items 9, 9a, and 9d
12. PATIENT'S CRIAUTHORIZED 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.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
below	
SIGNED Phil Holms DATE 7/24/09	SIGNED Phil Holms
14. DATE OF CURRENT (LUIESS, INJURY, or PREGNANCY (LMP) 15 OTHER DATE MM DD YY QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178	FROM OS O'S 3000 TO OS OS 3000
7, Henry Jones 176 NPI 19. ADDITIONAL CLAMMINFORMATION (Designated by NUCC)	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 /2 2000 TO 04 /2 2000
19. ADDITIONAL CLAIM NFORMATION (Designated by NUCC)	20 CUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	VES ✓ NO Ø .∞
C20-590	22 RESUBMISSION CRIGINAL REF NO.
E G H	23 PRICH AUTHORIZATION NUMBER
24. A DATE(S) OF SERVICE B C. D. PROCEDURES, SERVICES, CR SUPPLIES E. From To Ruber (Explain Unusual Circumstances) DIAGNOSIS	F. G H. I J. DAYS PEOT ID RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER	\$ CHARGES ON RAID OUAL PROVIDER ID.
09 12 00 09 25 00 ER 11 99213 21	E2 78 NPI /2353/99
1,000	E2 78 NPI /2353/99
	NPI
	NPI /2353/97 NPI /2353/97 NPI NPI
	NPI NPI
	NPI NPI
	NPI NPI
25 FEDERAL TAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use
32/876845 _ TL/2950 XYES NO	\$ 6278 \$ 0 00
31 S GNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO& PH# () Por Bop Circle
(I certify that the statements on the reverse	Boston pa
Chicago IC	42588
1	10700
SIGNED DATE "	a b



FICA			PICA TTT J
1 MEDICARE MEDICAID TRICARE CHAMPA	- HEALTH PLAN - BUK LUNG	1a INSUREDISTID NUMBER	(For Program in Item 1)
(Medicares) (Medicalds) (ID\$/DcDs) (Mamber) 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	OF (IDF) (IDF) (IDF) (IDF)	316354 Y 32 4 INSURED'S NAME (Last Name, First Name	A Existent full of the
Holms, Phillip, T	02 28 70 MX F	Holms, Phillip, T	e, wickie inia)
888 Strawberry Lane	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Steet)	1.
CITY	Self Spouse Child Other 8 RESERVED FOR NUCC USE	088 Straw borry	1.00
Paris Mo		Paris	FIE (Indude Area Code) FO 80 0 5 4 3 0 FUNDER
2P CODE TELEPHONE (Induct Nea Code) (65812 (660) 800 5 3 3 (NE (Indude Area Code)
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO:	65912 (6)	0) 8005730
		6657	Z
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 (Sale)	D OTHER CLAIM ID (Designated by NUCC)	
	YES NO L	STORY COMMITTO (CONSIGNATION (CONSIGNATION CONSIGNATION C	AND
C RESERVED FOR NUCCUSE	c OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM	
d INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d: CLAIM CCDES (Designated by NUCC)	Blue Cross d IS THERE ANOTHER HEALTH BENEFIT F	PLAN2
		***	ete Items 9, 9a, and 9d
BEAD BACK OF FORM BEFORE COMPLETING 12 PATIENT'S CR AUTHCRIZED PERSON'S SIGNATURE I authorize the	release of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSONS payment of medical benefits to the undersi	S SIGNATURE I authorize
to process this claim. Latso request payment of government benefits either below.	to myself or to the party who accepts assignment	services described below	1
SIGNED I'hil Itolmi	DATE 7/28/09	SIGNED Phil Holm	15
I MIM DD I YY	OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN	CURRENT OCCUPATION DD YY
05 09 2000 QUAL PAU QU 17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a		FROM 05 05 200 to 18 HOSPITALIZATION DATES RELATED TO MM DD YY	O 05 08 2000
	NPI	FROM 0 4 12 7020 T	004 12 2000
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 CUTSIDE LAB? \$1	CHARGES () 00
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serve	ce line tolow (24E) ICD Ind	22 RESUBMISSION CRIGINAL	
A L £00-49V BL CL	p		ner nu
EL	н	23 PRICE AUTHORIZATION NUMBER	
	DURES, SERVICES, CR SUPPLIES E In Unusual Circumstances) DIAGNOSIS	F G H. I	J
MM DD YY MW DD YY SERVICE EMG CPT/HCP		\$ CHARGES UNITS Rati QUAL	RENDERING PROVIDER ID. #
07 12 00 09 25 00 ER 11 992	13 21	\$2 78 NPI	1245319599
			Z (30) 13 17
		NPI	E E
		NPI NPI	<u>&</u>
			<u>ಸ</u>
		NPI	PROMOERID. # 12 \ 53 \ 95 99 NO NOW SHOW THE PROMOER IN THE PROM
		NPI	<u>o</u>
			HYS
25 FEDERAL TAX I D NUMEER SSN BIN 26 PATIENT'S A	CCOUNT NO. 27 ACCEPT ASSIGNMENT?	1 IPI 28 TOTAL CHARGE 29 AMOUNT P	
321876845 - tLKF	SD XYES NO		00
INCLUDING DEGREES OR OREDENTIALS 53573	LVrry Lan	33 BILLING PROVIDER INFO & PH# (6	53) 354 3248
(i certify that the statements on the reverse apply to this bit and are made a part hereof) Chi Carg		Doc Bop Circle Boston, PA	
8487	3	42588	
SIGNED DATE A		a NPI b	



PICA	PICA
1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER X (Medicare #) (Medicald #) (ID#000#) (Member ID#) (ID#) (ID#) (ID#)	1 a INSURED'S I D NUMSER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEN	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
5 PATIENT'S ADDRESS (No., Steel) 6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Sizel)
CITY Steely DY Self A Spouse Child Other	U2713 Streety D7
Springfield TELEPHONE (Include Area Code)	springfield MA
65432 (210 555-1145	ZIP CODE TELEPHONIE (Indude Area Code) 11 INSURED'S POLICY GROUP OR FECA NUMBER a INSURED'S DATE OF BIRTH B OTHER CLAIM ID IDESIgnated by NUCC) C INSURANCE PLAN NAME OF PROGRAM NAME d IST HERE ANOTHER HEALTH BENEFIT FLAN?
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 b. AUTO ACCIDENT? PLACE (Sale)	b. OTHER CLAIM ID. Designated by MUCC)
C RESERVED FOR NUCCUSE C OTHER ACCIDENT?	C INSURANCE PLAN NAME OF PROGRAM NAME
YES NO	My Homestate Health
d INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CCOES (Designated by NUCC)	d ISIT HERE ANOTHER HEALTH BENEFIT PLAN? YES NO II yes, complete liens 9, 94, and 9d
PEAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12 PATIENT'S CR AUTHORIZED PERSON'S SIGNATURE I authorize he release of any modical or other information necessary to process his claim. I also request gayment of government benefits given 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
below.	services described byłow
SIGNED	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD
MM DD YY OJAL OUAL MM DD YY 17 NAME CF REFERRING PROVIDER CR OTHER SOURCE 17a	FROM TO
17b NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 CUTSIDELAB? \$ CHARGES
21 DIAGNOSIS CRINATURE OF ILLNESS CRINUURY Relate A-L to service line below (24B) ICD Ind	22 RESURMISSION CRIGINAL REF NO.
A	23 PRICH AUTHORIZATION NUMBER
24 A DATE(S) OF SERVICE B C D PROCEDURES, SERVICES, OR SUPPLIES E.	F G. H. I J
From To RACEOF (Explain Unusual Oroumstances) DIAGNOSIS MM DD YY MM DD YY SERWCE EMG CPT/HCPCS MODIFIER PCINTER	S CHARGES UNITS PLIN CUAL PROVIDER ID.
01/12/19/01/05/19/	
	NPI
	I I I I
	NPI
	NPI NPI
	NPI NPI
25 FEDERAL TAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT? (For gover claims, see bads) YES NO	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use \$
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES CA CREDENTIALS	33 BILLING PROVIDER INFO & PH # ()
(I certify that the statements on the reverse a pply to this bit and are made a part hereof.)	
a	a NP b
SGRED DATE NI ICC Instruction Manual available at www.purc.org. DI FASE DRINT OR TYPE	APPROVED CMB-0938-1197 FCRM 1501 (02-12)



PICA			PICA TTT
1 MEDICARE MEDICAID TRICARE CHAMP X (Medicare#) (Medicaid#) (ID#OoD#) (Member	- HEALTH PLAN - BLK LUNG -	23435023	(For Program in flem 1)
2 PATIENT S NAME (Last Name, First Name, Middle Initial) Jone May L	3 PATIENT'S BIRTH DATE SEN	Jone Mary L	, Middle Initial)
42713 Steety Dr	6 PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7 INSURED'S ADDRESS (No. 504) 42713 Steety	Dr
Springfield STATE		CHY Springfield	1
ZIP CODE TELEPHONE (Indude Area Code)			IE (Include Area Code) 3) 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 FECAN	UMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX SEX
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 PROGRAM	SEX F X SHAME AME IN SORRED IN SORR
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAM CCDES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT F	Health HA
READ BACK OF FORM BEFORE COMPLETIN 12 PATIENT'S CRI AUTHCRIZED PERSON'S SIGNATURE I authorze to	NG & SIGNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSONS	
to process this claim. I also request payment of government benefits a the below	er to myself or to the party who accepts assignment	payment of medical benefits to the undersi services described below	gned physician or supplier for
SIGNED	DATE	SIGNED	
01 02 19 QUAL	OTHER DATE MM DO YY	16 DATES PATIENT UNABLE TO WORK IN DD YY TO	
	7a NPI	18 HOSPITALIZATION DATES RELATED TO MM DD YY TO	
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 CUTSIDE LAB? \$0	CHARGES
21 DIAGNOSIS CRINATURE OF ILLNESS CRINUURY Relate A-L to se	vice line below (24E) ICO Ind	YES NO 22 RESUBMISSION CODE CRIGINAL I	REF NO
B C C F C G	р <u></u>	23 PRICA AUTHORIZATION NUMBER	
1	L L L L L L L L L L L L L L L L L L L	F G H I	
	Iain Unusual Circumstances DIAGNOSIS	S CHARGES UNITS AID CUAL	RENDERING PROVIDER ID.
01 02 19 01 05 19		419 39 NPI	1245319599
		NPI	E
		NPI	
		NPI	PHYSICIAN OR SUPPLIER INFO
		NPI	CIAN
			PHYS
25 FEDERALTAX I D NUMBER SSN EIN 28 PATIENT'S	ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT P.	
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE F 31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE F 33 SERVICE F 34 ROLLUDING DEGREES OR CREDENTIALS 4 Certify that the statements on the reverse a pply to this bit and are made a part thereof)	FACILITY LOCATION INFORMATION	\$ \$ 33 BILLING PROVIDER INFO & PH# ()
SIGNED DATE a N	PI • 19	a NP1 a	+



PICA	PICA	Ĭ
1. MEDICARE * MEDICAID TRICARE CHAMPVA GROUP FECA OTHER BLY, LUNG (ID#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	R 1a. INSURED'S I D. NUMBER (For Program in Item 1)	1
2 PATIENT'S NAME (Last Name, First Name, Middle Inital) 3 PATIENT'S BIRTH DATE SEX 13 PATIENT'S BIRTH DATE SEX	4. INSUREDS FAME (Last Name, First Name, Middle Initial)	
5 PATIENT'S ADDRESS (No., Steet) 6. PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Szeet)	
CITY SELF & RESERVED FOR NUCC USE	CITY STATE	z
DEPTUTE TELEPHONE (Indude Area Code)	Neptune CA ZIP CODE TELEPHCIE (Indude Area Code)	PATIENT AND INSURED INFORMATION
87155 (878) 548 - 3257	87155 (878) 872 4872	ORM
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	DIN
a OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current or Previous)	a INSURED S DATE OF BRITH SEX MM I DD I V 9 M	SURE
b RESERVED FOR NUCC USE b AUTO ACCIDENT? PLACE (State)	10 3/169 M D F	Ν̈́Ω
c. RESERVED FOR NUCCUSE c OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	HAN
YES NO	Nepture Heathcare	
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO #/yes, complete items 9, 9a, and 9d.	l P
BEAD BACK OF FORM BEFORE COMPLETING & SIDNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for	il
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	services dissortised below	2
14 DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15 OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Y
07 3 GUAL QUAL MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178	FROM ON 11 2018 TO ON 8 2000	T
Will Grace 176 NPI	FROMO 6 13 2008 -03 20 2012	
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 CUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICO Ind	22 RESUBMISSION CRIGINAL REF NO	
	23. PRICE AUTHORIZATION NUMBER	1
1	F. G. H. I. J.	
From To RACEOF (Explain Unusual Croumstances) DIAGNOSIS MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER		ATTO
09 12:00109 25 001 8011 9921321	194 NPI 1245319599	ORM
	NPI	N N
		PHYSICIAN OR SUPPLIER INFO
	NPI NPI	SUF.
	NPI	ON
	NPI	SICI
	NPI	F
25. FEDERAL TAX IT NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use \$ 194 s	
31 SIGNATURE OF PHYSICIAN OR SUPPLIES 22 CODUING EACH TO A TICAL INFORMATION		
including degrees or credentials (I certify that the statements on the reverse apply to this bit and are made a part thereof) 84357 Statey Rd Springfield OR 79845	Cardy Cane Loop 557-9816 North Pole, LA 67662	
a NDI h	1 NP	J
SIGNED DATE	Approximate to the second seco	11



PICA			PICA
1. MEDICARE MEDICAID TRICARE (Medicare#) (Medicaid#) ((D#/DoD#)	CHAMPVA GROUP HEALTH PLAN (Member 10.4) (10.4) (10.4)	316kh87	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Init	I MM I DD i YY —— . I	4. INSURED'S NAME (Last Name, Fi	st Name, Middle Initial)
5 PATIENT'S APDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	MARS Ke H	The second secon
4482 Jefferson St 1	Ap) 33 Self X Spouse Child Other State 8 RESERVED FOR NUCC USE	4482 Jefferse	nd St Apt 23
Neptune	CA	Neptune	SEX F NUMBER SEX F NUMBER SEX F NUMBER NUCC) OGRAM NAME NEFIT PLAN?
ZIP COCE TELEPHONE (Include		ZIP CODE TE	LEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, M	Mode Initial) 10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POUCY GROUP OR	(878)8724872 E
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Ourrent or Previous)	INSURED'S DATE OF BIRTH	
a di nen inauneu a rouci un anour nomben	YES NO	MM DD BIRTH	SEX F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	ts. OTHER CLAIM ID (Designated by	NUCC)
c. RESERVED FOR NUCC USE		C. INSURANCE PLAN NAME OR PR	OGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. CLAIM CCDES (Designated by NUCC)	Neotune He	althrane
G. HAGOTINIAGE I GOA TANAGE GITT I I GOI INITIANIAGE	Tod. CENTI CODES (Designated by NOCC)	- I - I - 	s, complete items 9, 9a, and 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATUR	IRE COMPLETING A SIGNING THIS FORM. RE I authorize the release of any medical or differ information necessary nent benefits either to myself or to the party who accepts assignment	 payment of medical benefits to the 	ERSON'S SIGNATURE I authorize undersigned physician or supplier for
below \/ compiler 6 \ \Mosses	al-los	services described below	m
SIGNED VELOCITIES INJURY, or PREGNA	DATE \$12 03	SIGNED CITY 16 DATES PATIENT UNABLE TOW	OBK IN CUBBENT OCCUPATION
of 12 208 and fine	QUAL MM DD YY	FRCM05 11 2018	TO 02 08 2020
17. NAME OF REFERRING PROMDER OR OTHER SOL	URCE 17a 17b NPI	18 HOSPITALIZATION DATES RELIGION BATES RELIGION BA	TO 03 A2 20/2
19 ADDITIONAL CLAIM INFORMATION (Designated by		20 OUTSIDELAB?	⊈ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Relate A-L to service line below (24E) ICO Ind.	YES NO 22 RESUBMISSION CODE CA	1000 01
1 EOU-E90 BL	С		IGINAL REF NO
E F	G L H L	23 PRIOR AUTHORIZATION NUMB	ER
24. A. DATE(S) CF SERVICE B From To FLACEOF	C. D PROCEDURES, SERVICES, CA SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS	F. G H	I. J. RENDERING
MM DD YY MM DD YY SERVICE E	EMG CPT/HCPCS MODIFIER POINTER	\$ CHARGES UNITS RA	ID RENDERING CUAL PROVIDER ID.
09 12 00 09 25 00 ER	11 99213 21	0.94	
			NPI C
			NPI S
			NPI C
			Nal A
			NPI
25 FEDERAL TAX I D NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	4	OUNT PAID 30 Rsvd for NUCC Use
324879832	TLIGOKU 8 X YES NO	5 0,94 s	(654)5579816
INCLUDING DEGREES OR CREDE/ITALS (I certify that the statements on the reverse	84357 Stacy Rd Springfield, OR	Candy Cane Loo	p 17876
a poly to this bill and are made a part frerect)	Springfield, OR 19845	Candy Cane Loo North Pole, LA 67462	
SIGNED DATE	a a	6 14 4 P	
MLICC Instruction Manual available at www.	DUCC OF DI EACE DEINT OF TYPE	The last term of the last term of the	STRUBBLISHED FOR BM (500002-12)



PICA PICA	PICA TITL
HEALTH PLAN BLK LUNG	14 INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicare#) (ID#/OoD#) (Member 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)
Hunt Ethan S. 69 11 1990 MZ FL	Hund. Ethan S.
5. PATIENT'S ADDRESS (No.,)Steet) 6. PATIENT RELATICISHIP TO INSURED	7. INSURED'S ADDRESS (No., Steet)
CITY Set Spouse Child Cither STATE IS RESERVED FOR NUCC USE	CITY STATE Z
Glandale TX	Glendale TX
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:	1/4/84 (3/4)867-5309
n/q	STATE TO PEND OF TELEPHONE (Indude Area Code) TO STATE TO PEND OF TELEPHONE (Indude Area Code) TO STATE TO STAT
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?	b OTHER CLAIM ID (Designated by NUCC)
PLACE (State)	I O / Q
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?
The test of the te	YES NO II yes, complete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIDNING THIS FORM. 12. PATIENT'S CRI AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary.	13 INSURED'S OF AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government tenefits either to myself or to the party who accepts assignment below.	services described below.
SIGNED DATE	agned
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE ON 1 DO 1 YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	FROM 09 11 2019 TO 09 27 2019 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD MM OD YY
Dr. Brian Smith 176 NPI	FROM 09 10 2019 TO 09 13 2019
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 CUTSIDE LAB? \$CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to set wice line below (24E)	22 RESUBMISSION
A Head traine Broken Temorto Briller Fernor D	OUSIAL CHIGHAL REF. NO.
E Broken Ulma(L): Usroken Ulna(R) (R) H	23 PRICE AUTHORIZATION NUMBER
1.	F. G. H. I. J. Z
From To RACEOF (Explain Unusual Circumstances) DIAGNOSIS MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER PCINTER	
	NO.
	I I NPI
	NPI E
	NPI
	05
	NPI O
	Nel 194
	Ø. X
25 FEDERAL TAX I D. NUMBER SSN EN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	NP)
25 FEDERAL TAX I D. NUMBER SSN EN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For good chains, see bid.) YES NO.	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rs.vd.for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS	33. BILLING PROVIDER INFO & PH # ()
(I certly that the statements on the reverse apply to this bit and are made a part hereof.)	
S < 1/9/2/1	
SIGNED DATE DATE	a (42) b.



PICA	PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP BLX.UNG OTH MEDICAID (Medicaids) (ID\$\text{ID}\tex	(For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 2 PATIENT'S BIRTH DATE SEX DD 10 07 MX F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Leclerc, (Marles
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Steet)
280 Washington St Sell Spouse Child Other STATE B RESERVED FOR NUCC USE	1 777 Bockten AUC STATE
STATE B RESERVED FOR MUDC USE TELEPHONE (Include Area Code)	Abington MA ZIP CODE TELEPHONE (Include Area Code)
017-49 (123) 456 7890	02351 (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
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. RESERVED FCR NUCCUSE C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
YES NO	A STATE A S
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CCDES (Designated by NUCC)	d ISTHERE ANOTHER HEALTH BENEFIT PLAN? YES NO #yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIONING THIS FORM. 12 PATIENT'S CRIAUTHORIZED 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	services described below
14, DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15 OTHER DATE	SIGNED 16 DATES PATIENT LINAR E TO WORK IN CURRENT COCURATION
MM DD YY QUAL QUAL MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD DD TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NP1	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DD YY FROM TO
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 Incl.	22 RESUBMISSION CRIGINAL REF. NO
A. L	23. PRICE AUTHORIZATION NUMBER
I. L. K. L. E. L.	
24. A DATE(S) CF SERVICE B. C D PROCEDURES, SERVICES, CR SUPPLIES E. From To PLACEDF (Explain Unusual Orgunistances) DIAGNOS MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTE	
	NPI
	NPI NPI
	NPI
	NPI NPI
	NPI NPI
25 FEDERAL TAX 1 D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT	? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use
31 SIGNATURE OF PHYSICIÁN CA SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION	\$ \$ \$ 33 BILLING PROVIDER INFO & PH #
INCLUDING DEGREES OF CREDENTIALS (I certify that the statements on the reverse apply to this bit and are made a part hereof.)	
The first one are a company of boars and company to	
SIGNED DATE a b.	a NPI b
NUCC Instruction Manual available at liwww nucciord PLEASE PRINT OR TYPE	APPROVED CMB-0938-1197 FCRM 1500 (02-12)