

PICA			PICA
	HEALTH PLAN BLK LUNG	1a INSURED'S I D NUMBER	(For Program in Item 1)
(Med.care#) (Medicald#) (ID#/DoD#) (M	amber ID#) (ID#) (ID#) (ID#)  3. PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Na	t ()
Loveroud, Luna	06 13 87 M FX	Lovegord, Lun	
5. PATIENT'S ADDRESS (No , Steet)	6. PATIENT RELATIONSHIP TO INSURED	7 INSURED'S (DDRESS (No , Steel)	
TEV Webster or	Set Spouse Child Other	CITY	STATE
	TX PESENTED FORMOGE OSE	CITY	SIAIE
ZIP CODE TELEPHONE (Indude Area Code		ZIP CODE TELEPH	CNE (Include Area Code)
870311 (314)721-8000	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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Ourrent or Previous)	a. INSURED'S DATE OF BIRTH	SEX
	YES X NO	INITIAL DO TI	M F
b RESERVED FOR NUCC USE	D AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC	(1)
C RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRA	MINAME
	YES NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT	
READ BACK OF FORM BEFORE COMPI	ETING & SIONING THIS FORM.	YES NO If yes, com	rplete items 9, 9a, and 9d. NS SIGNATURE Lauthorize
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 author to process this claim. I also request payment of government tenefit:	ize the release of any medical or other information necessary —	payment of medical benefits to the unde services described below.	
telow	9/2019		
SIGNED CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP	DATE // DU/	SIGNED	
08   8   19 QUAL!	OUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK I	TO DX 1 75 19
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18 HOSPITALIZATION DATES RELATED	MM DD YX
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17b NPI	FROM 68 01 19	TO 58 02 19
19 ADDITIONAL CEMINIARION (Designated by 1000)		20 OUTSIDE LAB?	\$CHARGES 8000
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	to service line below (24E) ICD Ind	22. RESUBMISSION	L REF. NO.
A. L	c L D.L		L 1162 ; 1163
E F	G L H L	23. PRIOR AUTHORIZATION NUMBER	
	PROCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. DAYS EPSOT	
From To PLACE DF MM DD YY MM DD YY SERVICE EMG CF	(Explain Unusual Organistances) DIAGNOSIS T/HCPCS   MODIFIER POINTER	F. G. H. EFSOT II OR Family QU \$ CHARGES UNITS Flan QU	
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		- I NI	7
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25 FEDERALTAX I.D. NUMBER SSN BN 26 PATIE	ENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT	
24 CIONATURE OF BUYERO AN OR CUES US	YES NO	\$ \$	
INCLUDING DEGREES OR CREDENTIALS	ICE 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 flereof)			
SIGNED DATE a	D. PI FASE PRINT OR TYPE	a NP b	S-1197 FORM 1500 (02-12
NUCC Instruction Manual available at www.nucc.ord	PLEASE PRINT OR TYPE	VELLUANCE CINID-DR	ACTUAL CONTRACTOR OF THE PROPERTY OF THE PROPE



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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP EECA OTHER  (Medicare#) (Medicard#) (ID#DoD#) (Member ID#) (ID#) (ID#) (ID#)	1a INSURED'S I D. NUMBER (For Program in Item 1)  133 7 7331	
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)	$\exists$
5 PATIENT'S ADDRESS (NO. STEEL) 6 PATIENT RELATIONSHIP TO INSURED	Regardsoc, Kevin 7. INSSMED'S ADDRESS (No., Skeet)	- 1
231 Honey Load Sell Spouse Chid X Other	231 Honey Road	
Carthage STATE 8 RESERVED FOR NUCC USE	Carthage NC	ATION
76327 (SSS) 236 3520	ZIP CODE TELEPHONE (Indude Area Code)	3
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIBIT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER	NFO
A CTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Ourrent or Previous)	7 4 6 2 3 7 7 7 a. INSURED'S DATE OF BIRTH SEX	
1231129-2610 AES \( \text{NO}\)	ID 21 62 M	NSTIRED
b RESERVED FOR NUCC USE  b. AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)	ONA
c. RESERVED FOR NUCCUSE c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	
d INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	ATIFNT
	YES NO II yes, complete items 9, 9a, and 9d.	0
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 tenefits other to myself or to the grafty who accepts assignment.	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>	
Vian Randers 10/01/17	Kan Pala	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE  MM   DD   YY  MM   DD   YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MALE TO WORK IN CURRENT OCCUPATION OF THE PARTY OF THE	- <u>T</u>
MM DD YY 10 01 7 QUAL QUAL 17 17 17 17 17 17 17 17 17 17 17 17 17	FROM (C) (MEG) 13- TO (C) (MEG) 13-	_[
BJC 176 NP	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  WM DD YY  FROM 10 0 17 TO 10 10 17	
19. ADDITIONAL CLAM INFORMATION (Designated by NUCC) Some Mare info of Jame Kind	20. CUTSIDELAB? \$ CHARGES	
21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	22. RESUBMISSION CRIGINAL REF. NO. 7	7
E Staffy resc EL	23. PRIOR AUTHORIZATION NUMBER	
1 L L/Omit J L K L L L L L 24 A DATE(S) OF SERVICE B C D PROCEDURES, SERVICES, CR SUPPLIES E	828214	_
From To RACEUF (Explain Unusual Croumstances) DIAGNOSIS  MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER	F. G. H. I. DAYS EPEOT ID. RENDERING CR Family S.CHARGES UNITS Fan QUAL PROVIDER ID. #	NO F
[0 01 17 10 80 17   X IDK     IDK	1000 99 10 NPI 246322	RMAT
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25 FEDERALTAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	NPI 28 TOTAL CHARGE 29, AMOUNT PAID 30, Rsvd for NUCC U:	
\$189923 - 1001245 NVES NO	s 1000 99 s 823 74	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS () certify that the statements on the reverse  (CO Weaker Plaza	33. BILLING PROMDER INFO & PH. (636) (73 4567	7
apply to this bit and are made a part hereof)  Lake St. Law 5 Mo 193367	Example Billing provider	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse applyto this bit and are made a part hereof)  SIGNED MAN JOANNE DATE  32. SERVICE FACILITY LOCATION INFORMATION  WEALTH COMMAND AND THE PROPERTY OF THE	a b	
NLICC Instruction Manual available at www.num.org	APPRIORED WHENEXES BY LEVEL MEROUPS	-



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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP  (Medicare#) (Medicard#) (ID#/DoD#) (MemberID#) (ID#)	PLAN BLK LUNG	1a INSURED'S I.D NUMBER	(For Program in Hem 1)
2 PATIENT'S NAME (Last Name, First Name, Mode Initial) 3. PATIENT'S B	ATH DATE SEX	/5 8 6 7 9 4 4. INSURED'S NAME (Last Name, Fir	st Name. Middle Initial)
Stark, Tony M. OI OI	1 YY	Stark, Tony	M
5. PATIENT'S ADDRESS (No , Street) 6. PATIENT RE	ATIONSHIP TO INSURED	7, INSURED'S ADDRESS (No., Stee	1)
13 Park Place Sell Specific State B RESERVED	ouse Child Other	13 Park 1	Place
New York NY	. OH NOCC USE	New Yor!	K STATE
ZIP CODE TELEPHONE (Indude Area Code)	K	ZIP CODE TE	LEPHONE (Include Area Code)
11217 (555) 555 6419		11217	(535) 555 6419
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. EMPLOYME	IT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
6479 X	YES NO	01 DD YY	M X F
B. RESERVED FOR NUCC USE b. AUTO ACCID	ENT? PLACE (State)	b. OTHER CLAIM ID (Designated by	NUCC)
C RESERVED FOR NUCCUSE C. OTHER ACC	YES NO NO	c. INSURANCE PLAN NAME OF PRO	PLEPHCNE (Include Area Code)  (\$35) \$55 6415  FECA NUMBER  SEX  M   NUCC)  DGR AM NAME
	YES NO	LOO	DOLLINA IAVINE
	DES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BE	NEFIT PLAN?
Cool	576		s, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THE 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize the release of any model.	lical or other information necessary	payment of medical benefits to the	RSON'S SIGNATURE I authorize undersigned physician or supplier for
to process this claim. I also request psymant of government benefits either to myself or to the below	party who accepts assignment	services described below	7 _
SIGNED DATE		SIGNED_	
14. DATE OF CURRENT ILINESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE	MM   DD   YY	16. DATES PATIENT UNABLE TOW	CRK IN CURRENT OCCUPATION
02 03 20 and In) and 03	03 30 30	FROM 64 90  18. HOSPITALIZATION DATES RELA	10 05 05 50
Darke	en S	FROMO6 66 66	TO 07 07 70
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. CUTSIDE LAB?	\$ CHARGES
Here is into		YES NO	47 20
21. DIAGNOSIS OF NATURE OF ILLNESS OF INJURY Relate A-L to service line below 24	ICD Ind.	22. RESUBMISSION CR	IGINAL REF, NO.
E Punched & Cut face & Snap	ا <u>ا کی اً ا</u> ا ا اکٹ	23. PRICE AUTHORIZATION NUMBER	<i></i> 4
Broken Leg J Stock in machine K fly	powel	2442	
24. A DATE(S) OF SERVICE B. C D PROCEDURES, SERVIC From To RACEOF (Explain Unusual Circuit	nstances) DIAGNOSIS	F. G. H. DAYS EPS OR FINIT S CHARGES UNITS FAT	I J ID RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS	MODIFIÉR POINTER	S CHARGES UNITS PAR	ID RENDERING OUAL PROVIDER ID. #
01/02/63/01/11/03/4/x/ knee a	Ludx	20 20 1	
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0105 66 61 14 06 a x foot 2	y x w x	50 St 4	NPI 106
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01 07 08 61 16 08 c x head 2	XWX	70 70 0	NPI 108
25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT?		OUNT PAID 30 Rsvd for NUCC Use 700   16 / 04
77777 3667 0 3	NINFORMATION/	\$ 760 76 \$	,01
INCLUDING DEGREES OR CREDENTIALS () certify that the statements on the reverse			(616) 553 4312
apply to this bil and are made a part thereof.)	5 T	7 1	
	/	(001	,
SIGNED DATE  NUCC Instruction Manual available at www nucc org PLEA:	SE PRINT OR TYPE	APPROVED OME	-0908-1197 FORM 1500 (02-12)



PICA	PICA TITLE
— — — HEALTH PLAN — BLK LUNG —	HER 1a INSURED'S LD. NUMBER (For Program in Item 1)
(Medicares) (Medicards) (ID\$/DoD\$) (ID\$/DoD\$) (ID\$/DoD\$) (ID\$/DoD\$) (ID\$/DoD\$/DoD\$/DoD\$/DoD\$/DoD\$/DoD\$/DoD\$/D	0 10576321  4 INSURED'S NAME (Last Name, First Name, Middle hillal)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 2 PATIENT'S BIRTH DATE SEX NM DD Z 86 MV F	Smith, Jane, S
5. PATIENT'S ADDRESS (No., Steet) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Steet)
14 Marlowe St. Sell Spouse Child Char	1 1334 Hillshire Rd
STATE NO RESERVED FOR NUCC USE	O'Fallon MO
ZIP CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Include Area Code)
63116 (314) 562-3521	63366 (6%) 281-4253
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  10. IS PATIENT'S CONDITION RELATED TO	2IP CODE 63366 TELEPHONE (Include Area Code) 63366 (636) 281-4253  11. INSURED'S POLICY GROUP OR FECA NUMBER 652A345  a. INSURED'S DATE OF BIRTH MM   DD   DZ   QO   M   F   V  10   02   QO   M   F   V  ate) b. OTHER CLAIM ID (Designated by NUCC)
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
D RESERVED FOR NUCC USE IN AUTO ACCIDENT?	10 02 90 M FV
PLACE (Sta	b. OTHER CLAIM ID (Designated by NUCC)
C. RESERVED FOR NUCCUSE  C. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
VES NO	Anthem CDH
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
Anthem PPO	YES VNO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release 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
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 JOHN DOC DATE 10/1/2019	SIGNED Jame Smill
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 115. OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
OS OS Q QUAL MM DD YY	FROM 05 03 14 TO 07 11 14
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
17b NPI	FROM 06  1  14 TO  0 07  19
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS CRINATURE OF ILLNESS CRINUURY Relate A-L to service line below (24E) ICD Ind	22. RESUBMISSION CRIGINAL REF. NO.
A (Branchit's B C D	23 PRIOR AUTHORIZATION NUMBER
E	— 23. PHIOR AUTHCHIZATION NUMBER
24. A DATE(S) OF SERVICE B. C D. PROCEDURES, SERVICES, OR SUPPLIES E.	F G. H. i. J.
From To PLACE OF (Explain Unusual Circumstances) DIAGNO MM DD YY MM DD YY SERVICE EMG CPT/HCPCS ( MODIFIER POINTE	F.   G.   H.   i.   J.
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25 FEDERAL TAX I.D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT, ASSIGNMENT	197
25 FEDERAL TAX I D NUMBER SSN EN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT UZ S63714 SCD XYZZY YES NO	197
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FACILITY LOCATION INFORMATION	T? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS () certify that the statements on the reverse	17? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use 5 \$6   1 Z   \$ 586   1 Z
15 C D X Y Z Z Y YES VNO  31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS  32 SERVICE FACILITY LOCATION INFORMATION	17? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use 5 \$6   1 Z   \$ 586   1 Z
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS () certify that the statements on the reverse	17? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use 5 \$6   1 Z   \$ 586   1 Z



PICA			PICA
1. MEDICARE         MEDICAID         TRICARE         CHAMPVA           ▼ (Afedicare#)         (Afedicaid#)         (ID#/DcD#)         (Member ID#	GROUP FECA OTHER HEALTH PLAN BLK LUNG (ID#)	12 INSURED'S I D NUMBER 8675309	(For Program in Item 1)
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)
LARRY Hupert  [5 PATIENT'S ADDRESS (No. 5 Peet)	6 PATIENT RELATIONSHIP TO INSURED	MUMGY BODENS	
1023 Nano Rd	Self Spouse Child Other	23 bon drive	
ave STATE AL	RESERVED FOR NUCC USE	CITY L. 1	STATE
ZIP CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHO	NE (Indude Area Code)
63023 (314)111-5008		36974 (11.	3)234-6783
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  Ben Tenneson	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECAN	NE (Include Area Code) 3) 234 - 6783  RUMBER  SEX F  NAME  NAME  PLAN?
	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX SE
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
	YES NO		AN
c RESERVED FCR NUCC USE	C. OTHER ACCIDENT?  TYES NO	c. INSURANCE PLAN NAME OR PROGRAM	NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT F	PLAN?
READ BACK OF FORM BEFORE COMPLETING	A SIONNO THIS FORM	YES NO If yes, compliant insurance of Authorized Persons	ete items 9, 9a, and 9d
12. PATIENT'S CRI AUTHORIZED PERSON'S SIGNATURE. I authorize the rel to process this claim. I also request payment of government benefits after to	lease of any medical or other information necessary	payment of medical benefits to the undersi services described below.	
SIGNED Dawn Numphra	x/99/24	Som Allen	dn
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. O	THER DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN	CUPRENT OCCUPATION
02 05 33 QUAL	MM DD YY	FROM TO	0
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.	NP)	18. HOSPITALIZATION DATES RELATED TO MM DD YY T	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		l	CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELEGIBLATED SERVO	e line below (24E) (CD tnd	22 RESUBMISSION CRIGINAL	
ALA BL CL	D. L.		REF. NO.
ELIVA FL. GL		23 PRIOR AUTHORIZATION NUMBER	
	URES, SERVICES, OR SUPPLIES E. Unusual Circumstances) DIAGNOSIS	F. G. H. I. DAYS EFFOT ID	J. RENDERING
MM DD YY MM DD YY SERVICE EMG OPT/HÖPC		\$ CHARGES UNITS FIND QUAL	
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		No.	
		NPI	٥
		NPI	PHYSICIAN OR SUPPLIER INFO
	1 1 1 1 1	1 1 1	NA
		NPI	<u> </u>
25 FEDERALTAX I D NUMBER SSIVEN 26 PATIENT'S AC	CONTRICT ACCICABATE TO	28 TOTAL CHARGE 29 AMOUNT F	
25 FEDERAL TAX ID NUMBER SSYEN 26 PATIENTS AC	27 ACCEPT ASSIGNMENT? (For gove claims, see bid.)  YES NO	\$ 5348   92   \$ 5000	PAID 30 Rsvd.for NUCC Use 7/92
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FAC	CILITY LOCATION INFORMATION	33 BILLING PROMDER INFO & PH # (	)
(I certify that the statements on the reverse apply to this foll and are made a part thereof.)	um Dr. Facility		
Selle Sells	J		
SIGNED DATE a.	DI CACE DOINT OF TYPE	a b.	Υ



PICA			PICA T
1. MEDICARE MEDICAID TRICARE CHAMPV  (Medicalds) (IDs/DcOs) (Members)	- HEALTH PLAN - BEKLUNG -	1a. INSURED'S I.D. NUMBER 8675309	(For Program in Hern 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIATH DATE SEX	4 INSURED'S NAME (Last Name, First I	Name, Middle Initial)
Durighety, Mixt, I	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No. Sheet)	M
5201 Mulhollard Dr.	Self Spouse Child Other	2407 FOR L	-A.
	8 RESERVED FOR NUCC USE	CITY Saulluilla	STATE
ZIP CODE TELEPHONE (Indude Area Code)		ZIP CODE TELE	PHCNE (Include Area Code)
92/30 (573)903-5768			347) 976-5204
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO.	11. INSURED'S POLICY GROUP OR FE	CA 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?	b OTHER CLAIM ID (Designated by NU	M
	YES NO L	b OTHER CEANING (Designated by NO	cc)
C. RESERVED FCR NUCCUSE	c. OTHER ACCIDENT?  YES NO	C INSURANCE PLAN NAME OR PROG	RAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENE	PHCNE (Include Area Code) 377) 976 - 570 9 CA NUMBER  SEX  M  CC)  RAM NAME
			omplete items 9, 9a, and 9d
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government trenefits after	elease of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERS payment of medical benefits to the un</li> </ol>	
telow Dough	25 14 020	services described below.	- 3-
SIGNEE  14 DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15	DATEOTHER DATE	SIGNED	40
MM DD YY CUAL	MM i DD i VV	16. DATES PATIENT UNABLE TO WOR	TO CURRENT OCCUPATION TO YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a		18. HOSPITALIZATION DATES RELATE	
17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	NP1	FROM 28 OUTSIDE LAB?	TO \$CHARGES
		YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	(CD Ind.	22 RESUBMISSION CRIGI	NAL REF, NO.
A.L   B.L   C.L.   C.L.   G.L.   G.L.	D. L Н. L	29. PRICE AUTHORIZATION NUMBER	
	DURES, GERVICES, OR SUPPLIES E	F. G H.	
	in Unusual Circumstances) DIAGNOSIS	DAYS EPSOT OR Family	NPI NPI NPI NPI
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25 FEDERALTAX I D NUMBER SSN EIN 26 PATIENT'S /	CCOUNT NO. 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOU	1971
	YES NO	\$ 5	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I) Certify that the statements on the reverse	CILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH #	( )
apply to this bit and are made a part hereof)			
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SIGNED DATE "  NUCC Instruction Manual available at www.nucc.org	DI EASE DRING OR TYPE		CECULIARIE MELETANDE PARA



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1. MEDICARE MEDICAID TRICARE CHAMPVA AROUS ECA OTHER LECA OTHER (Medicares) (M	1 1a INSURED'S LD NUMBER (For Program in Nem 1)
2 PATIENT'S NAME (Last Name, First Name, Mode Initial) 3 PATIENT'S BIRTH DATE SEX 5 M 02 1960 MX F	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Steet) 6. PATIENT RELATIONSHIP TO INSURED  173 STREET ST. Set Spouse Child Cities	7. INSURED'S ADDRESS (No., Sheet) 123 STREET ST
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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
a. OTHER INSURED'S POLICY OR GROUP NUMBER  13 245 (9 8 AB C YES NO	a INSURED'S DATE OF BIRTH  OMM DO ZOOO M SEX  F
b RESERVED FOR NUCC USE  b AUTO ACCIDENT?  PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
c. OTHER ACCIDENT?  YES NO	C. INSURANCE PLAN NAME OR PROGRAM NAME  SURANCE PLAN
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO Wyes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12 PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process his claim. I also regiest payment of confirmation in the party who accepts assignment.	INSURED'S OF AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned psysician or supplier for services described below.
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 CUTSIDE LAB? SCHARGES VES NO   \$6543   43
21. DIAGNOGIS CR NATURE OF ILLNESS CR INJURY Relate A-L to ser wælline below (24E)	22 RESUBMISSION CRIGINAL REF. NO. 1234
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25 FEDERAL TAX JD. NUMBER SSN EN 26 PATIENT'S ACCOUNT NO 127 ACCEPT ASSIGNMENT? 12345678 YES NO	\$ 500 00 \$ 500 00 8 Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse applyto the bit and are finade a part thereof.)  32. SERVICE FACILITY LOCATION INFORMATION  42. VICTOR CATCOMINECTMENT OF THE PROPERTY O	33 BILLING PROVIDER INFO & PHO RILLING PROVIDER
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1. MEDICARE MEDICAID TRICARE CHAM  (Medicare#) (Medicald#) (ID#/DoD#) (Member)	HEALTH PLAN BLK LUNG	1a INSURED'S I D. NUMBER 987665	(For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name	
Key Francis 5  5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No. 8	IS S
É 1600 Pennsylvania AVENW	Self A Spouse Child Other	1600 Pennsyl	vania Ave NW
Washington DC		Washington	TELEPHONE (Include Area Code) (7/2) 476-4648 OR FECA NUMBER 32 4 3 SEX M F H by NUCC) PROGRAM NAME
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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	(7/2) 476-4648 OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	THE OVERTITE (Owner) or Proving	9578	3243
a. OTHER INSURED S POLICY OR GROUP NOMBER	a. EMPLOYMENT? (Current or Previous)  YES  NO	a INSURED'S DATE OF BIRTH	SEX F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designate)	d by NUCC)
C RESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR	PROGRAM NAME
	YES NO	Cigna	,
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d ISTHERE ANOTHER HEALTH	HENEFIT PLAN?  Wyss, complete Items 9, 9a, and 9d
READ BACK OF FORM BEFORE COMPLET  12. PATIENT'S CR AUTHORIZED PERSON'S SIGNATURE Lauthorize to	NO & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZE	D PERSON'S SIGNATURE I authorize
to process this claim. Latso request payment of government benefits eat- below.		services described below.	o the undersigned physician or supplier for
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19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	7t NPI	FROM 09 14 14	1009 17 19
19. ADDITIONAL CEAM INFORMATION (Designated by NOCC)		20. OUTSIDE LAB?  YES NO	\$CHARGES
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apply to this bit and are made a part thereof )	The state of the s	St-Louis N	
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1. MEDICARE MEDICAID TRICARE CHAMP	VA GROUP FECA OTHER	1a INSURED'S I.D. NUMBER (For Program in Hem t)
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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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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	YES NO	03 19 64 M
	b. AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c OTHER ACCIDENT?	C INSURANCE PLAN NAME OF PROGRAM NAME
	YES NO	Anthem
d. INSURANCE PLAN NAME OR PROBRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	1234 A	YES NO Hyes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to	O & SIGNING THIS FORM.	13. INSURED'S CH AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.		services described below
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	a l	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 CUTSIDE LAB? \$ CHARGES
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Fletate A-L to se	wide line below (24E) ICD Ind.	22. RESUBMISSION CAIGINAL REF. NO.
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INCLUDING DEGREES OR CREDENTIALS (I cerally that the statements on the reverse	The state of the s	
apply to this bill and are made a part thereof.)		
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NUCC Instruction Manual available at www.nucc.org	PLEASE PRINT OR TYPE	APPROVED CMB-0936-1197 FORM 1500 (02-1



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HEALTH PLAN BLK LUNG	HER 12 INSURED'S1.D NUMBER (For Program In Hem 1)
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  Ruydon  Mike  A  PATIENT'S BIRTH DATE SEX  ON  ON  F  III  III  SEX  ON  F  III  III  III  III  III  III  I	4 INSURED'S NAME (Last Name, First Name, Middle Initial)  But to a Alex M
5 PATIENT'S AUDRESS (No., Steel)  6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (M.S., Steet)
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8 11/0 (314) 6 19-99	2IP CODE   TELEPHONE (Include Area Code)   (7/4) 451- 8884
9. OVEHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
	Blue (res)
a. OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
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Who PLACE (Sh	(te) b OTHER CLAIM ID (Designated by NUCC)
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what YES NO	Blue (m)
d INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
HOW III 522	YES NO #yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING A SIGNING THIS FORM.  12. PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessar to process this darm. I also request payment of government tenefits other to myself or to the party who accepts as signiment.	13. INSURED'S CA AUTHORIZED PERSON'S SIGNATURE Lauthorize payment of medical benefits to the undersigned physician or supplier for services described below
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19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 OUTSIDE LAB? \$CHARGES
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21. DIAGNOSIS OR NATURE OF ILLNESS CRI INJURY Relate A-L to service time below (24E)	22 RESUBMISSION CRIGINAL REF. NO. 57125 B100000
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24. A DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES E. From To RACEOF (Explain Unusual Circumstances) DIAGNO	F. G. H. I. J. DAYS EPOT ID RENDERING
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25 FEDERAL TAX I.D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT	T? 28 TOTAL CHARGE 29 AMOUNT PAID 30 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# (512) 5 V 1-5441
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NUCC Instruction Manual available at www nucc org PLEASE PRINT OR TYPE	APPROVED CMB-0998 1197 FCAM 1500 (02-12)



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1. MEDICARE         MEDICAID         TRICARE         CHAMF           X (Medicare#)         (Medicald#)         (ID#/DoD#)         (Membe	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Hem 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	2 PATIENT'S BIRTH DATE	649430 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., Steet)
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New York NY	B RESERVED FOR NOOC USE	Vew York STATE
ZIP CODE TELEPHONE (Indude Area Code)	-	ZIP CODE TELEPHONE (Include Area Code)
1000-1 (555) 555-4367	<b>'</b>	10007 (555) 555 -4367
9. OTHER INSURED'S NAME (Last Name, Arst Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER
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	YES X NO	A INSURED'S DATE OF BIRTH  12 MM 1 DD 19 80 M X F
b RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
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C. RESERVED FOR NUCC USE	C. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM (CDES (Designated by NUCC)	ZIP COOE  JOUO 7  TELEPHONE (Include Area Code)  (555) 555 -4367  11. INSURED'S POLICY GROUP OR FECA NUMBER  6 7 7 7 4 3 2  a. INSURED'S DATE OF BIRTH  JOD 14 80 M F  b. OTHER CLAIM ID (Designated by NUCC)  C. INSURANCE PLAN NAME OR PROGRAM NAME  GOLL  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
Gold	, , , , , , , , , , , , , , , , , , , ,	YES NO // yes, complete items 9, 9a, and 9d
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to process his claim. I also request payment of government benefits either below	er to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below
SIGNED BEB	9-27-19	Enfor
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15	DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	7b NPI	FROM TO  20 OUTSIDE LAB? \$CHARGES
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21. DIAGNOSIS OR NATURE OF ILLNESS CR INJURY Relate A-L to se	r woe line below (24E) ICD Ind	22. RESUBMISSION CODE CODE CRIGINAL REF. NO
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31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE	FACILITY LOCATION INFORMATION	\$96,000,000 °C \$ 90,000 00 00 00 00 00 00 00 00 00 00 00 0
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	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (ID#)	1a INSURED'S LD NUMBER (For Program In Item 1)
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)
GROTGES John L 5 PATIENT GADDLESS (NO. STEE)	6 PATIENT RELATIONSHIP TO INSURED	Georges John L 7 INSURED S PLORESS (No. Steet)
4706 TAMM Ave	Self Spouse Child Other	4706 Tomin Ave
St. Lovis #	STATE 8 RESERVED FOR NUCC USE	CITY ST. Louis  ZIP CODE 6 3/39  TELEPHONE (Include Area Code) (3/34) 757 - 6319  11 INSURED'S POLICY GROUP OR FECA NUMBER  a INSURED'S DATE OF BIRTH MM   DD   YY D 2   17   1949 M F  b. OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OR PROGRAM NAME  d IS THERE ANOTHER HEALTH BENEFIT PLAN?
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- CT. IFD ING 1870/2 DOLLOV CD 2004/2 DAWN 250		
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)  YES NO	a INSURED SDATE OF BIRTH  MM   DD   YY  D 3   17   1949 M F
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	YES NO	9.73
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CCDES (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 COM 12 PATIENT'S CR AUTHORIZED PERSON'S SIGNATURE   auth	thorize 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 undersioned drysician or supplier for
to process fills class I also request payment of government bene below	nefits either to myself or to the party who accepts assignment	services described below
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14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LA	MP) 15 OTHER DATE OUAL MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD DD
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17h NPI	FROM TO 20 CUTSIDE LAB? \$CHARGES
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse a pay to this bill and are made a part fiered.)	YES   NO ERVICE FACILITY LOCATION INFORMATION	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
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1. MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP HEALTH PLAN	BLK LUNG	A 12 INSURED'S I D NU	MBER	(For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle In	(Member ID4)	(ID#)	(104) (104)	71601	16442	16. de 20. 3. 16. 43.
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ZIP CODE TELEPHONE (Induct	AND DESCRIPTION OF THE PERSON			ZIP CODE		NE (Include Area Code)
63140 (314)660	16677			- Ti	10	4) 667 - 6677
9. OTHER INSURED'S NAME (Last Name, First Name, I	viiddle initial) 10	IS PATIENT'S CON	DITION RELATED TO			NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER				GC 28	34116	
a OTHER INSURED S PODCT ON GROOP NOWBER	la c	EMPLOYMENT? (Cu YES	NO NO		IO /- O	w FIX
b. RESERVED FOR NUCC USE	b A	UTO ACCIDENT?	PLACE (State	0	Designated by NUCC)	
		YES	× NO L			
C. RESERVED FOR NUCCUSE	c. 0	THER ACCIDENT?	[ <del>[</del> ]	C. INSURANCE PLAN	IAME OF PROGRAM	NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	104	CLAIM CODES/D	NO esignated by NUCC)	TELEPHONE (Include Area Code)  (314) 667 · 6677  (314) 677 · 677  (314) 677  (3		
	1,000			\$77		
READ BACK OF FORM BEF	ORE COMPLETING & 8	IGNING THIS FORM	her Information necessary		THORIZED PERSON	S SIGNATURE I authorize
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize the release of any medical or other information to process fills claim   also request payment of government tenefits either to myself or to the party who accepts assisted ow				payment of medical services described to	penerits to the unders	gned physician or supplier for
SGNED amio SAKamyth		DATE 9	30 2019	ans On	min Mida	with
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNA		R DATE				
9 10 2019 QUAL	QUAL	9	11 2019	FROM MM DD	1 1	O MM DD YY
17 NAME OF REFERRING PROVIDER OR OTHER SO					DATES RELATED TO	CURRENT SERVICES
Dr. Terri Johnson  19 ADDITIONAL CLAIM INFORMATION (Designated by	NUCC) 17th NP	1		110		The state of the s
				1077 June	11 2	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to set vice line below (24E) (CD Ind.				22 RESUBMISSION CODE	CRIGINAL	
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24 A DATE(S) OF SERVICE B.		ES, BERVICES, OR			G H. I	J
From   To   PL/DEBF   MM   DD   YY   SERVICE	EMG CPT/HCPCS	usual Circumstance MODIF			OR PARTIES ID.	RENDERING PROVIDER ID. #
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25 FEDERALTAX I.D. NUMBER SSN EIN	26 PATIENT'S ACCO	UNT NO 27	ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29 AMOUNT F	
196.32.6443 X	62588 A		YES NO	\$31190 1	70 \$ 32	100
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32 SERVICE FACILIT			39. BILLING PROMDER		14) 682 3194
(I certify that the statements on the reverse apply to this full and are made a part thereof.)	Barnes Je	wish Hos	pital	Barnes J		
	5t. Louis	, MO 6	3123	Mary Ka		
SIGNED DATE	a	b.		2	b.	
NHCC Instruction Manual available at www	DI LOS OLO	DI CAOC DE	INT OF TYPE	ADDET	WELL MARIEN	1197 FT BM 1501 (12.12)



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MEDICARE MEDICAID TRICARE CHAMPA	— HEALTH PLAN — BLK LUNG —	R 1a INSURED'S I.D NUMBER	(For Program in Item 1)	
(Medicares) (Medicaids) (ID\$/DoD\$) (Member)		A12356 2443	45 I.C I.C II.	
PATIENT'S NAME (Last Name, First Name, Middle Initial)  Jones D Davy	3. PATIENT'S BIRTH DATE SEX	Jones Davy	Name, Miccie Initial)	
PATIENT'S ADDRESS (No., Sred)	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)		
155 Brown St	Self X Spouse Child Other	155 Brown 5	†	
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57. LOUIS MO	4	St. Louis	MO	
		100.00.000	27HONE (Include Area Code)	
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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 ACCOENT? PLACE (State	b OTHER CLAIM ID (Designated by NU	JCC)	
RESERVED FOR NUCCUSE	C OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROG	A AM NAME	
	YES X NO	Ambetter	=	
NSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CCDE6 (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENE	EFIT PLAN?	
	No. of the second secon	YES X NO Hyes,	comptele items 9, 9a, and 9d	
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	release of any medical or other information necessary.	13. INSURED'S OR AUTHORIZED PER- payment of medical benefits to the un		
to process this claim, I also request payment of government banefits either below	to myself or to the party who accepts assignment	services described below.	# · · · · · · · · · · · · · · · · · · ·	
SIGNED Da'ry Dones	DATE 10-1-2019	SIGNED ADOVE AND	Zones	
DATE OF CURRENT UNESS, INDURY, OF PREGNANCY (LMP) 15.	OTHER DATE		NK IN CURRENT OCCUPATION	
9 28 2019 QUAL QU	1 9 2 2019	FROM 912812019	TO	
NAME OF REFERRING PROVIDER OF OTHER SOURCE		18. HOSPITALIZATION DATES RELATE	TO CURRENT SERVICES	
Dr. Matthew Roark 174  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	1 NPI	FROM 9 28 2019	TO 9 30 2017	
Property of the Control of the Contr		YES NO	2 398   76	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	tce line below (24E) 1CD Inct.	22 DECLIDATECTON	100	
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1 1A FL GL	н 🗀	23. PRIOR AUTHORIZATION NUMBER		
A DATE(S) OF SERVICE   B   C.   D. PROCE	EDURES, SERVICES, OR BUPPLIES ) E.	629194A	J.	
	ain Unusual Orcumstances) DIAGNOSI	S DAYS EPSOT	ID. RENDERING QUAL PROVIDER ID. #	
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23.56.2443 T A3898	NO YES NO	s 2 398 76 s	0 00	
SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE FA	CILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH #	(314) 782-496	
(I certify that the statements on the reverse apply to this bill and are made a part thereof)	s Jewish Hospital	Juri Janko		
apply to this direct and are made a part vicion		The state of the state of		
of O 1 St. Lou	115 , M(0	But Billing		