HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 4861W0976	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Lovegood, Luna	3. PATIENT'S BIRTH DATE MM DD YY: 06 13 87 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Lovegood, Luna
5. PATIENT'S ADDRESS (No., Street): 789 Wesley St	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street):
CITY: Edinburgh STATE: TX	8. RESERVED FOR NUCC USE	CITY: STATE:
ZIP CODE: 87051 TELEPHONE (Include Area Code): (314) 721-8004		ZIP CODE: TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):	b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem	10d. CLAIM CODES (Designated by NUCC):	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Luna Lovegood DATE: 9/30/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 09 19 QUAL:	15. OTHER DATE QUAL: MM DD YY:	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 08 09 19 TO 08 13 19
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:	17a: 17b. NPI:	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 08 01 19 TO 08 02 19
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 8000
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: A: B: C: D: E: F: G: H: I: J: K: L:		22. RESUBMISSION CODE: ORIGINAL REF. NO.: 23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 08 09 19	08 09 19		✓				3800	1		NPI	427692
2 08 09 19	08 02 19						1000	1		NPI	1097814
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

HEALTH INSURANCE CLAIM FORM

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

PICA ☐ ☐ PICA ☐

1. MEDICARE ☒ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoD#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 13377331

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] Regardsoe, Kipp	3. PATIENT'S BIRTH DATE: MM 11 DD 03 YY 64 SEX: M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Regardsoe, Kevin
5. PATIENT'S ADDRESS (No., Street): 231 Honey Road	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☒ Other ☐	7. INSURED'S ADDRESS (No., Street): 231 Honey Road
CITY: Carthage STATE: NC	8. RESERVED FOR NUCC USE	CITY: Carthage STATE: NC
ZIP CODE: 28327 TELEPHONE (Include Area Code): (885) 236 3520		ZIP CODE: 28327 TELEPHONE (Include Area Code): (685) 236 3641
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Regardsoe, Joe	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: 714823177
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789 10	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH: MM 10 DD 21 YY 62 SEX: M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) ☐	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Kipp Regardsoe DATE: 10/01/17

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Kevin Regardsoe

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 10 DD 01 YY 17 QUAL:	15. OTHER DATE QUAL: MM 10 DD 03 YY 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 10 01 17 TO 10 10 17
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BJC	17a: 17b. NPI:	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 10 01 17 TO 10 10 17
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Some more info of some kind		20. OUTSIDE LAB? ☒ YES ☐ NO $ CHARGES:
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.: A. Broken Arm B. C. D. E. Stuffy nose F. G. H. I. Vomit J. K. L.		22. RESUBMISSION CODE: ABC ORIGINAL REF. NO.: 003417
		23. PRIOR AUTHORIZATION NUMBER: 828214

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 10 01 17	10 10 17		X	IDK		IDK	1000 99	10		NPI	246322
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 8189923 SSN EIN	26. PATIENT'S ACCOUNT NO.: 1001245	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE: $ 1000 99	29. AMOUNT PAID: $ 523 74	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: Mary Hockey DATE: 10/20/17	32. SERVICE FACILITY LOCATION INFORMATION: 100 Medical Plaza Lake St. Louis MO 63367 a. NPI b.	33. BILLING PROVIDER INFO & PH #: (636) 123 4567 Example Billing Provider a. NPI b.			

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1586794
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stark, Tony, M	3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 19 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Stark, Tony, M	
5. PATIENT'S ADDRESS (No., Street): 13 Park Place	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13 Park Place	
CITY: New York STATE: NY	8. RESERVED FOR NUCC USE: OK
CITY: New York STATE: NY	
ZIP CODE: 11217 TELEPHONE (Include Area Code): (555) 555 6419	
ZIP CODE: 11217 TELEPHONE (Include Area Code): (555) 555 6419	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Bob, Billy, G	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 6	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 6479	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
a. INSURED'S DATE OF BIRTH MM 01 DD 01 YY 19 SEX M [X] F [ ]	
b. RESERVED FOR NUCC USE: OK	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC): 474	
c. RESERVED FOR NUCC USE: Sure	c. OTHER ACCIDENT? [X] YES [ ] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: Cool	
d. INSURANCE PLAN NAME OR PROGRAM NAME: Cool	10d. CLAIM CODES (Designated by NUCC): 676
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: Tony DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: Tony

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 02 DD 02 YY 20 QUAL Inj	15. OTHER DATE QUAL 03 MM 03 DD 30 YY 30
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 04 04 40 TO 05 05 50	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Parks	17a: Cool; 17b. NPI: beans
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 06 66 TO 07 07 70	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Here is info	20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 47 20
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	22. RESUBMISSION CODE: 24 ORIGINAL REF. NO.: 42
A. Dead B. Burned Arm C. Gauntlet D. Suit E. Punched F. Cut face G. Snap H. Ice I. Broken leg J. Stuck in machine K. fly L. power	23. PRIOR AUTHORIZATION NUMBER: 2442

	24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1	01 02 03 01 11 03	Y	X	knee	a b c d	X	20	20	1	NPI	103
2	01 03 04 01 12 04	Y	X	arm	z y x w	X	36	30	2	NPI	104
3	01 04 05 01 13 05	2	X	leg	a b c d	X	40	40	3	NPI	105
4	01 05 06 01 14 06	a	X	foot	z y x w	X	50	50	4	NPI	106
5	01 06 07 01 15 07	b	X	hand	a b c d	X	60	60	5	NPI	107
6	01 07 08 01 16 08	c	X	head	z y x w	X	70	70	6	NPI	108

25. FEDERAL TAX I.D. NUMBER: 777771 SSN EIN: 3667	26. PATIENT'S ACCOUNT NO.: 103	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 700 70	29. AMOUNT PAID: $ 700 16	30. Rsvd for NUCC Use: 104

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: TC DATE:

32. SERVICE FACILITY LOCATION INFORMATION: Building A a: A b:

33. BILLING PROVIDER INFO & PH #: (616) 555 4312 Cool a: B c:

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 10576321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John, E

3. PATIENT'S BIRTH DATE: MM 10 DD 2 YY 86 SEX: M [✓] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 14 Marlowe St.

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

7. INSURED'S ADDRESS (No., Street): 1334 Hillshire Rd

CITY: St. Louis STATE: MO

8. RESERVED FOR NUCC USE

CITY: O'Fallon STATE: MO

ZIP CODE: 63116 TELEPHONE (Include Area Code): (314) 562-3521

ZIP CODE: 63366 TELEPHONE (Include Area Code): (636) 281-4253

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Venus, Mars, E

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 652A345

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 00532164D

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

a. INSURED'S DATE OF BIRTH: MM 10 DD 02 YY 90 SEX: M [ ] F [✓]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [✓] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem CDH

d. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem PPO

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [✓] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED: John Doe DATE: 10/1/2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED: Jane Smith

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 05 DD 03 YY 19 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 05 03 19 TO 07 11 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 06 11 19 TO 10 02 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [✓] NO $ CHARGES

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

A Bronchitis B C D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 03 24 19	04 01 90						586 12	2		NPI	1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 42563214 SSN EIN

26. PATIENT'S ACCOUNT NO.: BCDXYZ24

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

28. TOTAL CHARGE: $ 586 12

29. AMOUNT PAID: $ 586 12

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: DATE: 11/2/19

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 8675309 (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LARRY Hupert

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

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

5. PATIENT'S ADDRESS (No., Street): 1023 Nano Rd

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

7. INSURED'S ADDRESS (No., Street): 23 bon drive

CITY: Quantum ave STATE: AL

8. RESERVED FOR NUCC USE

CITY: Laferty STATE: AK

ZIP CODE: 63023 TELEPHONE (Include Area Code): (314) 111-5008

ZIP CODE: 36974 TELEPHONE (Include Area Code): (113) 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 FECA NUMBER: 123456789

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1169420

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

a. INSURED'S DATE OF BIRTH MM DD YY: 01 21 94 SEX M [✓] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [✓] If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Danny Murphy DATE 8/98/34

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Danny Murphy

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 05 33 QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. NO B. C. D.

E. NA F. G. H.

I. yes J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1	03	13	19	05	15	55	M	M	OPT	1 3 4 6		5348 92	3	B	NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: 13-156789 [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 5348 92

29. AMOUNT PAID $ 5000 42

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: Quantum Dr. Facility

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	8675309	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Daugherty, Merle, I	09 21 2017 M [X] F [ ]	Clark, Kent, M
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
5201 Mulholland Dr.	Self [ ] Spouse [ ] Child [ ] Other [X]	2407 Farm Ln.
CITY: Metropolis — STATE: IL	8. RESERVED FOR NUCC USE	CITY: Smallville — STATE: KS
ZIP CODE: 92130 — TELEPHONE (Include Area Code): (573)903-5768		ZIP CODE: 54204 — TELEPHONE (Include Area Code): (347) 976-5204
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
		921305
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX
		07 27 1987 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Merle Daugherty DATE: 27 May 2020

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Clark Kent

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1 06 27 18 06 14 18									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [X] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456 78ABCD

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SEAN SISKORSKI

3. PATIENT'S BIRTH DATE: 01 | 02 | 1980 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 STREET ST

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

7. INSURED'S ADDRESS (No., Street): 123 STREET ST

CITY: CITYPLACE STATE: MO

8. RESERVED FOR NUCC USE

CITY: CITYPLACE STATE: MO

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 456-7890

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 453-7890

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123456 7AB

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 132456 78ABC

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

a. INSURED'S DATE OF BIRTH: 01 | 01 | 2000 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: INSURANCE PLAN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: [signature] DATE: 01/01/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: [signature]

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 | 01 | 2001 QUAL: QUAL

15. OTHER DATE QUAL: 01 | 01 | 01

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 12 | 12 | 2001 TO 01 | 03 | 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: REFERRING

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 01 | 04 | 1984 TO 05 | 21 | 1988

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: $6543 | 43

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

A: YES B: C: D:

E: NO F: G: H:

I: YES J: K: L:

22. RESUBMISSION CODE: 123 ORIGINAL REF. NO.: 1234

23. PRIOR AUTHORIZATION NUMBER: 456789

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID. #
1	01 02 01	02 04 03	M	M	OPT	1 2 3 4		500 00	3	A			X	1234
2														NPI
3														NPI
4														NPI
5														NPI
6														NPI

25. FEDERAL TAX I.D. NUMBER: 12-3456 78 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 1234567890

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

28. TOTAL CHARGE: $ 500 00

29. AMOUNT PAID: $ 500 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: [signature] DATE: 1/2/19

32. SERVICE FACILITY LOCATION INFORMATION: SERVICE FACILITY

a. NPI b.

33. BILLING PROVIDER INFO & PH #: ( ) BILLING PROVIDER

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 98766 5449

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Key, Francis S

3. PATIENT'S BIRTH DATE MM DD YY: 01 05 49 SEX M [✓] F [ ]

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

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

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

7. INSURED'S ADDRESS (No., Street): 1600 Pennsylvania Ave NW

CITY: Washington STATE: DC

8. RESERVED FOR NUCC USE

CITY: Washington STATE: DC

ZIP CODE: 20500 TELEPHONE (Include Area Code): (712) 476-4648

ZIP CODE: 20500 TELEPHONE (Include Area Code): (712) 476-4648

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 9578243

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY: 01 05 49 SEX M [✓] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [✓]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Cigna

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [✓] If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED [signature] DATE 10/1/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED [signature]

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 14 2019 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 09 14 19 TO 09 20 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Jones

17a

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 09 14 19 TO 09 17 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [✓] $ CHARGES

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

A A00-B99 B G80125 C H40125 D

E D520.89 F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: XY2123

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09 14 19	9 17 19	11	N	123	12 4 5	19 XY	5000 00	3		NPI	123456
2 09 18 19	9 20 19	11	N	456	17 4 92	19 AB	5000 00	1		NPI	79812
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 43-17345 [ ]

26. PATIENT'S ACCOUNT NO.: 12597

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

28. TOTAL CHARGE $ 10000 00

29. AMOUNT PAID $ 0

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [signature] DATE 9/20/19

32. SERVICE FACILITY LOCATION INFORMATION: St Louis MO

a. NPI b.

33. BILLING PROVIDER INFO & PH# (314) 124-9999

Happy Trails Farm Rd

St Louis Mo 12345

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Aguilar, Mario

3. PATIENT'S BIRTH DATE MM 03 DD 19 YY 64 SEX M [✓] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Main St

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

7. INSURED'S ADDRESS (No., Street): 123 Main St

CITY: St. Louis STATE: MO

8. RESERVED FOR NUCC USE

CITY: St. Louis STATE: MO

ZIP CODE: 63088 TELEPHONE (Include Area Code): ( )

ZIP CODE: 63088 TELEPHONE (Include Area Code): (123) 515 3125

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: X14C4

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM 03 DD 19 YY 64 SEX M [✓] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [✓] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): 1234 A

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [✓] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 06 DD 01 YY 19 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 06 01 19 TO 07 01 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: St. Lukes

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 01 19 TO 06 03 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [✓] NO $ CHARGES 1234.56

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

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 06 01 19	06 03 19	11	✓				1234 56	3		NPI	X42102XX
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [✓]

26. PATIENT'S ACCOUNT NO.: 56589800,

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

28. TOTAL CHARGE $ 1234 56

29. AMOUNT PAID $ 0

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [signature] DATE 06/30/19

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

1 MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 111111

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

3. PATIENT'S BIRTH DATE: 08 | 4 | 19 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1111 Fair St

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

7. INSURED'S ADDRESS (No., Street): 1111 Fair St

CITY: St. Louis STATE:

8. RESERVED FOR NUCC USE

CITY: St. Louis STATE: MO

ZIP CODE: 61119 TELEPHONE (Include Area Code): (314) 519-9998

ZIP CODE: 61119 TELEPHONE (Include Area Code): (314) 451-8884

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: Blue Cross

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

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

a. INSURED'S DATE OF BIRTH: 1 | 15 | 87 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE: Who

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

b. OTHER CLAIM ID (Designated by NUCC): 1115121

c. RESERVED FOR NUCC USE: What

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross

d. INSURANCE PLAN NAME OR PROGRAM NAME: How

10d. CLAIM CODES (Designated by NUCC): 111522

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: [signature] DATE: 1/1/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: [signature]

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 08 | 15 | 15 QUAL: 11111

15. OTHER DATE QUAL: 1 5 MM: 9 DD: YY: 18

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM: 4 5 9 TO: 1 1 5

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Doctor Man

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM: 1 5 10 TO: 5 10 20

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Huh?

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

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

A. Sick B. Ouch C. to D. elbow
E. Dislocated F. How G. So H. Head
I. Pain J. much K. Sad L. Leg

22. RESUBMISSION CODE: 5 7 12 5 ORIGINAL REF. NO.: 5100000

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 | 1 | 2 | 1 | 1 | 2 | 1 | 5				CPT	With	a K	1000	5	N	NPI	1100001
2 | 1 | 2 | 1 | 1 | 2 | 1 | 5										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 1111111 SSN EIN: 7015

26. PATIENT'S ACCOUNT NO.: 100021

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

28. TOTAL CHARGE: $ 1000

29. AMOUNT PAID: $ 200

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: [signature] DATE: 5/5

32. SERVICE FACILITY LOCATION INFORMATION: St. Louis

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (512) 501-5441

St. Louis

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 649420

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Banner, Bruce, Bear

3. PATIENT'S BIRTH DATE: MM 12 DD 30 YY 1980 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 6 Park Place

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

7. INSURED'S ADDRESS (No., Street): 6 Park Place

CITY: New York STATE: NY

8. RESERVED FOR NUCC USE

CITY: New York STATE: NY

ZIP CODE: 10007 TELEPHONE (Include Area Code): (555) 555-4367

ZIP CODE: 10007 TELEPHONE (Include Area Code): (555) 555-4367

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: 6777432

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: MM 12 DD 30 YY 1980 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Gold

d. INSURANCE PLAN NAME OR PROGRAM NAME: Gold

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED: Bruce Banner DATE: 9-27-19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED: Bruce Banner

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 04 DD 01 YY 19 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM 09 DD 01 YY 19 TO MM 09 DD 01 YY 25

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BJL

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. Decapitation B. Green Skin C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09 01 19	09 13 19	B	X	Gamma Treatment		↑	90,000,000 00			NPI	1
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 65423

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

28. TOTAL CHARGE: $90,000,000 00

29. AMOUNT PAID: $ 90,000,000 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

1 MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a INSURED'S I.D. NUMBER (For Program in Item 1)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Georges, John, L

3 PATIENT'S BIRTH DATE: 03 | 17 | 1949 SEX: M [X] F [ ]

4 INSURED'S NAME (Last Name, First Name, Middle Initial): Georges, John L

5 PATIENT'S ADDRESS (No., Street): 4706 TAMM Ave

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

7 INSURED'S ADDRESS (No., Street): 4706 Tamm Ave

CITY: St. Louis | STATE: MO

8 RESERVED FOR NUCC USE

CITY: St. Louis | STATE: MO

ZIP CODE: 63139 | TELEPHONE (Include Area Code): (314)757-6319

ZIP CODE: 63139 | TELEPHONE (Include Area Code): (314)757-6319

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER

a OTHER INSURED'S POLICY OR GROUP NUMBER

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

a INSURED'S DATE OF BIRTH: 03 | 17 | 1949 SEX: M [X] F [ ]

b RESERVED FOR NUCC USE

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

b OTHER CLAIM ID (Designated by NUCC)

c RESERVED FOR NUCC USE

c OTHER ACCIDENT? YES [ ] NO [X]

c INSURANCE PLAN NAME OR PROGRAM NAME

d INSURANCE PLAN NAME OR PROGRAM NAME

10d CLAIM CODES (Designated by NUCC)

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED: John Lopez DATE: 09/13/2019

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED: John Lopez

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM | DD | YY QUAL

15 OTHER DATE QUAL MM | DD | YY

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

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

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

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

A B C D

E F G H

I J K L

22 RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25 FEDERAL TAX I.D. NUMBER SSN EIN

26 PATIENT'S ACCOUNT NO

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

28 TOTAL CHARGE $

29 AMOUNT PAID $

30 Rsvd for NUCC Use

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION

a NPI b

33 BILLING PROVIDER INFO & PH # ( )

a NPI b

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): A12399 6443

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

3. PATIENT'S BIRTH DATE: MM 5 DD 7 YY 1962 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 24789 Reitz Rd

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

7. INSURED'S ADDRESS (No., Street): 24789 Reitz Rd

CITY: St Louis STATE: MO

8. RESERVED FOR NUCC USE

CITY: St Louis STATE: MO

ZIP CODE: 63140 TELEPHONE (Include Area Code): (314) 667 6677

ZIP CODE: 63140 TELEPHONE (Include Area Code): (314) 667-6677

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: GC289176

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: MM 5 DD 7 YY 1962 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Ambetter

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED: Janie M Smith DATE: 9.30.2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED: Janie M Smith

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 9 DD 10 YY 2019 QUAL

15. OTHER DATE: QUAL MM 9 DD 11 YY 2019

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Terri Johnson

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM 9 DD 10 YY 2019 TO MM 9 DD 16 YY 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 4629 08

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

A 6521 B A6854 C B23 D

E F G H

I J K L

22. RESUBMISSION CODE: ORIGINAL REF. NO: A6629

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 9 10 2019	9 16 2019	MO	BJC	HCPCS	6 0 88	A123	25999 62	6	X	NPI	TJ8542
2 9 17 2019	9 17 2019	MO	BJC	OPT6	7 16 3A	B621	562 00	1	X	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 196 32 6443 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 62588A

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

28. TOTAL CHARGE: $ 31 190 70

29. AMOUNT PAID: $ 321 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: Barnes Jewish Hospital St. Louis, MO 63123

a. b.

33. BILLING PROVIDER INFO & PH#: (314) 682 3144 Barnes Jewish Hospital Mary Kay

a. b.

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): A123562443

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones D Davy

3. PATIENT'S BIRTH DATE: 6 | 9 | 1959 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 155 Brown St

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

7. INSURED'S ADDRESS (No., Street): 155 Brown St

CITY: St. Louis STATE: MO

8. RESERVED FOR NUCC USE

CITY: St. Louis STATE: MO

ZIP CODE: 63141 TELEPHONE (Include Area Code): (314) 314.3144

ZIP CODE: 63141 TELEPHONE (Include Area Code): (314) 314.3144

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: G32689

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 6 | 9 | 1959 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Ambetter

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED: Davy D Jones DATE: 10-1-2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Davy D Jones

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 9 | 28 | 2019 QUAL:

15. OTHER DATE: QUAL: 9 | 28 | 2019

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 9 | 28 | 2019 TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Matthew Roark

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 9 | 28 | 2019 TO 9 | 30 | 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 2,398 | 76

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

A. 32C B. 10B C. 823B D.
E. 1A F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 32916 ORIGINAL REF. NO.: 31000

23. PRIOR AUTHORIZATION NUMBER: 629184A

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 9 28 2019	9 30 2019	11	STL	B A5896	X	3298	2398 76	2	X	NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 123.56.2443 SSN EIN

26. PATIENT'S ACCOUNT NO.: A38987

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

28. TOTAL CHARGE: $ 2398 | 76

29. AMOUNT PAID: $ 0 | 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: Matthew Roark DATE:

32. SERVICE FACILITY LOCATION INFORMATION: Barnes Jewish Hospital St. Louis, MO

a. b.

33. BILLING PROVIDER INFO & PH#: (314) 782-4966 Jerri Janko BJH Billing

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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