

PICA										Р	CATT
	ICAID TRICARE	CHAMPVI (Mamber III	- HEALTH	I PLAN	FECA BLK LUN (ID#)	G OTHER	1a INSURED'S I.D 65539787	NUMBER	(F	or Program in the	am 1)
	lame, First Name, Middle Ini	لسا	3 PATIENT'S E	ARTH DATE		ا السا	4 INSURED'S NAME	E (Last Name, Fir	st Name, Mick	de hibali	-
Tyler, Liv			09 30	90	M	FX	Tyler, Steve				
PATIENT'S ADDRESS (* 104678 Vine	o Street)		6 PATIENT RE				7 INSURED'S ADDE	, _,)	9713	
OTY		STATE	Sell Sp B RESERVED		USE	Other	CITY	, ,		STA	TE
Hollywood		CA					New York				Υ
IP CODE	TELEPHONE (Indud						ZIP CODE	TE		dude Area Code)
54376 OTHER INSURED'S NAM	(212) 5544 E (Last Name, First Name,		10 IS PATIENT	'S CONDITI	ON RELA	TED TO	01234	CY GROUP OR		5554444	
		,					4536426				
OTHER INSURED'S POL	ICY OR GROUP NUMBER		a EMPLOYME	¬ '			a INSURED'S DATE			SEX	
RESERVED FOR NUCC	USE		b AUTO ACCIO	YES ENT?	X NO		06 06		M X	F	_
				YES	X NO	PLACE (State)	5. OTHER CEXIMIC	(Designated by	voce,		
RESERVED FOR NUCC	USE		c OTHER ACC	-			c. INSURANCE PLAI		DGFI AM NAM		
INSURANCE PLAN NAM	E OR PROGRAM NAME		10d. CLAIM CC	YES DES (Dasio	NO X		myhealthpla		VECIT OLAND		
THE OFFICE CENTERS	2 0011 1103117001171112		Tod. CEAIN CC	orb (besig	nated by I	1000)	YES	7		ens 9, 9a, and 9d	i
	EAD BACK OF FORM BEF RIZED PERSON'S SIGNATU				r informatio	on necessary	13 INSURED'S OR /				
	o request payment of govern						servoes describe		unuersigneu	prysider or sup	are ro
SIGNED			DATE				SIGNED				
DATE OF CURRENT IL	INESS, INJURY, or PREGN		OTHER DATE	MM i	00 (YY	16 DATES PATIENT	UNABLE TOW	CRK IN CURE	ENT OCCUPAT	JÔN
07 OI 19	CUAL PROVIDER OR OTHER SO	QU NIBCE 470					FRCM 18 HOSPITALIZATIO		то		
NAME OF HEFEMAING	PHOVIDEN ON OTHER SC		NPI				FROM	DD YY	TO TO COL	M DD	ΥΥ
ADDITIONAL CLAIM IN	FORMATION (Designated by	(NUCC)					20 OUTSIDE LAB?	100	\$ CHAF	IGES	
DIAGNOSIS OS NATUR	RE OF ILLNESS OR INJURY	Polate & Liberary	en tion holow (24		-		YES	NO 01			
k35.3		TIERRE AL DISCH	CC 1816 CC-OH (24	ICD	11.7	į.	22 RESUBMISSION CODE	CR	GINAL REF	NO	
	B [_ GL			D L		23 PRICE AUTHOR	IZATION NUMBE	A		
A DATE(S) OF SE	J. L RVICE B. I	C D PROCE	DURES, SERVIC		L L	T E	F	1 0 14			
From DD YY MIN	To PLACEOF	(Expla	in Unusual Circui			DI AGNOSIS PCINTER	\$ CHARGES	DAYS EPEC CR FAME UNITS AU	ID QUAL	RENDERI PROVIDER	
07 01 19 07	23 19			1	1				NPI 1	245319599	
	7.										
									NPI		
	1 1 1 1		1	- 1	1	1		1 1	NPI		
									1	بالدر في	
					1				NPI		
1 1 1			1 1	-	1	100		1	NPI		
		1							NPI		
5 FEDERALTAXID NU	VIBER SSN EIN	26 PATIENT'S	ACCOUNT NO		CEPT AS	SI SEE BLOS	28 TOTAL CHARGE		OUNT PAID 23498:5	30 Rsvd for	NUCC Use
SIGNATURE OF PHYS INDUDING DEGREES (I certify that the statem applyto this toll and are	CR CREDENTIALS ents on the reverse	32 SERVICE FA	CILITY LOCATIO			Ino	33 BILLING PROVI)	
ICHED	DATE	a	b.				a NPI	ь			
IGNED	DATE Tual available at www	N DUCC OLG	DI CA	SE PRIN	IT AP 7	.vne	APPE	TOVED CME	LD036-110	ZELBM 15	11/12/12



PICA										PICA
1. MEDICARE MEDICAL		CHAMPV	HEALTH PLAT		JNG	1a INSURED'S I.D. NO	MBER		(For Program)	n Item 1)
(Medicares) (Medicalo 2 PATIENT'S NAME (Last Nam		(Member IE	(ID#) 3. PATIENT'S BIRTH	(104)	(10.0)			. 5	A A A A A A A A A A A A A A A A A A A	
Johnson, Roberto		,	02 22 8	YY	F X	4. INSURED'S NAME (Williamson, S			, Middle Initial)	
5 PATIENT'S ADDRESS (No. 1			6 PATIENT RELATIO			7, INSURED'S ADDRE				
15 Alpha St			Self Spouse	Child	Other	97 Lane Driv	e			
CITY		L	8 RESERVED FOR I	NUCC USE		СІТУ			1	STATE
Ozark	Table and the state of the stat	Мо	Abi- i4-			Ladue				МО
62405	(721) 212223		this is sparta			ZIP CODE 42.41.1			lE (Include Area C	
9. OTHER INSURED'S NAME (, , , , , , , , , , , , , , , , , , , ,		10 IS PATIENTS CO	NOITION BE	ATED TO	42411 11. INSURED'S POLIC	Y GBOUE		2) 224243:	
	,	,								
a OTHER INSURED'S POLICY	OR GROUP NUMBER		a. EMPLOYMENT? (0	Ourrent or Pre	vious)	a. INSURED'S DATE C	F BIRTH		SEX	
AI1I11111IALIAI17I			X YES	لسا	Ю	02 42	80	M	×	F
NOT RESERVED			b. AUTO ACCIDENT?		PLACE (State)	b. OTHER CLAIMID (Designate	d by NUCC)		
c. RESERVED FOR NUCC USE			C OTHER ACCIDENT		143	c. INSURANCE PLAN I	NAME OF	PROGRAM	NAME	
THINGS			XYES		10	7 hearts				
d. INSURANCE PLAN NAME O	R PROGRAM NAME		10d. CLAIM CCDES (Designated b	y 14UOC)	d. IS THERE ANOTHE	R HEALTI	H BENEFIT P	LAN?	
			4562L52		•				elle Items 9, 9a, an	
12. PATIENT'S OR AUTHORIZE		Lauthorize the r	elease of any medical o	r other informa		13 INSURED'S OR AU payment of medical	benefits t			
to process this claim. I also re tielow	quest payment of governmen	it cenetits either i		•	ssignment	services described l	oelaw.			
SIGNED			DATE 09/	/23/19		SIGNED				
14. DATE OF CURRENT ILLNE	SS, INJURY, or PREGNANC		OTHER DATE	IM DD	YY	16. DATES PATIENT U	NABLEJ	O WORK IN		PATIÇN
(DUAL NO	QU/	AL			FRCM 02 12			02 15	80
17. NAME OF REFERRING PRO John Doe	OMDER OR OTHER SOUR	17a 17b	+			18 HOSPITALIZATION MM DD FROM	DATES	Υ	MM DD L	VICES YY
19 ADDITIONAL CLAIM INFOR	MATION (Designated by NJ		0794234			20 OUTSIDE LAB?		\$ C	CHARGES	
this is hurting						XYES	NO		42.42	
21. DIAGNOSIS CRINATURE C	FILLNESS CRINJURY Re	elate A-Litoserv	ce line below (24E)	ICD Ind		22. RESUBMISSION		CRIGINAL F	PEE NO	
A Lbeta	_B sigma	° c L		ــا .ه	,	ABC		4219	167 . 1464	
E (zeta	_F alpha	g L		нШ		23. PRIOR AUTHORIZ	ATION N	JMBER		
24. A. DATE(S) OF SERVI	J. L. B. C	K. L.	DURES, SERVICES, C	L. L PA SUPPLIES		42067257 F.	G.	H. I.] ,	
From	TO PLACE OF DD YY SERVICE EM	(Expta	in Unusual Circumstand		DIAGNOSIS POINTER	S CHARGES	DAYS CR UNITS	FRINITY ID.	REND PROVID	ERING
						1 24 102				
12 24 23 06	10 42 NJ	452	2		Α	9999 99	2	NPI	42156	
8 85 14 02	00 12 MO	c904	5	7		500 14		1 -55	67245	
0 00 14 02	OU 12 MO	C304	1 1 5		8	300:14	1	NPI	67345	
15 27 6 5	02 56 AL	1568	4		С	20 13	4	NPI	22221	
	1 1	1		1		11/1				
99 12 14 4	01 75 MO	2567		Α	D	1 34	5	NPI	47800	
02 15 78 56	21 82 IL	1342	В	1 1	E	717 77		1	E0004	,
OF 10 10 30	21 UZ IL	1342	1 8		-	111:11	6	NPI	56201	
02 11 11 44	42 41 NJ	2541	6		F	2000 00	7	NPI	888888	
25 FEDERAL TAX I D NUMBE	(4)	6 PATIENT'S A	CCOUNT NO 2	1 1	SSIGNMENT?	28 TOTAL CHARGE		AMOUNT P		for NUCC Use
8x447529252 31 SIGNATURE OF PHYSICIAL		07250006	CHECK LOCATION IN	YES	NO	s 14463			0,00	
INCLUDING DEGREES OR	CREDENTIALS	achivice ha	CILITY LOCATION INF	CHIMATION		33 BILLING PROVIDE	# IMFO &	rn. ()	
(I certify that the statements apply to this bit and are mad										
				T						-
SIGNED	DATE	1 1	b.			a NP	D.			
UCC Instruction Manua	l available of www.n	ucc ord	DIEACES	PINT OR	TYDE	APPRI	W/4-1) (MISCHARIE	1197 FCHM	LOCKER



APPHOVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) UZ		PICA
	MPVA GROUP FECA OTHER HEALTH PLAN (ID#) (ID#)	1a INSURED'S I D. NUMBER (For Program in Item 1) 8675309
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Hamilton, Lewis	3 PATIENT'S BIRTH DATE SEX O1 07 85 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5 PATIENT'S ADDRESS (No., Steet) 1600 pennsylvania Ave NW	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Ciner	7. INSURED'S ADDRESS (No., Steet)
CITY ST.	ATE 8 RESERVED FOR NUCC USE	CITY STATE
Washington D ZP CODE TELEPHONE (Indude Area Code)).	ZIP CODE TELEPHONE (Include Area Code)
()		()
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Prewous) X YES NO	a INSURED'S DATE OF BIRTH SEX
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	
Keal Good Insurance Plan	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 COMPLE PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize to process this claim. I also request payment of government benefits at below.	e the release of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	9/27/18	SIGNED
DATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LMP)	15. OTHER DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION PROM TO TO YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a 17b NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO YY TO WATER TO SERVICES
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELAID	icbing	22 RESUBMISSION CRIGINAL REF. NO.
	G H L	23. PRIOR AUTHORIZATION NUMBER
4. A. DATE(S) OF SERVICE B. C D. PR From To R.ACEOF (6	ROCEDURES, SERVICES, OR SUPPLIES Explain Unusual Circumstances) AHCPCS MODIFIER POINTER	F. G H I J DAYS EPSOT ID RENDERING CR RITER SCHARGES UNITS Ran QUAL PROVIDER ID. #
		NPI NPI
		NPI NPI
		, NPI
		NPI
		NPI NPI
		NPI NPI
5 FEDERALTAXID NUMBER SSN EIN 26 PATIEN	17'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For gove claims, see back) YES NO	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC US
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certly that the statements on the reverse apply to this bill and are made a part thereof.)	CE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH # ()
RIGNED DATE	NPI b	a N2 a
LOG laster than Manual an allebta at the second	DI CLOC DOUGLAS TUDA	Carlot - Budding a Budding of the American Street Company of the C



MEDICARE MEDICAID TRICARE CHA		PICA T
	PVA GROUP HEALTH PLAN BLK LUNG OTHER (ID#) (ID#).	1a INSURED'S I.D NUMBER (For Program in lism 1) 15372892S
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)
Robert, Smith, L	09 31 86 MX F	Jones, Blake, R 7. INSURED'S ADDRESS (No. Steet)
47 Rue De Grand	Self Spause Child Other X	
TY ST	TE B RESERVED FOR NUCC USE	CITY STATE
63367 N PCODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Indude Area Code)
()		()
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
THE INC. INC. INC. INC. INC. INC. INC. INC.		
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Ourrent or Previous) X YES NO	a. INSURED'S DATE OF BIRTH SEX
RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	X YES NO	
RESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	C INSURANCE PLAN NAME OR PROGRAM NAME
NSURANCE PLAN NAME OR PROGRAM NAME	YES X NO 10d CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
	(0.00)	YES NO #yes, compete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLE PATIENT'S CRI AUTHORIZED PERSON'S SIGNATURE L'authorize	ING & SIGNING THIS FORM. 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 physician or supplier for
to process this claim. It also request payment of government benefits a below	her to myself or to the party who accepts assignment	services described below
SIGNED	DATE	SIGNED
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15 OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
QUAL	QUAL	FROM TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO TO YY
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	I/U I/PI	20 OUTSIDE LAB? \$CHARGES
		YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to	er woe line below (24E) (CD Ind.	22. RESUBMISSION CODE CRIGINAL REF. NO
B L	D. L.	23 PRIOR AUTHORIZATION NUMBER
F. L.	H L L	
	OCEDURES, SERVICES, CA SUPPLIES E. XIII ain Unusual Orcumstances) DIAGNOSIS	F. G. H. I. J. J. PAYS EPSOT ID RENDERING
	HCPCS MODIFIER PCINTER	S CHARGES UNITS Ran QUAL PROVIDER ID. #
		NPI NPI
		NPI NPI
1 1 1 1 1 1 1 1	1 1 1 1 1	1
		NPI
		NPL
		NPI NPI
		NPI
FEDERALTAX I D NUMBER SSN BN 26 PATIEN	"S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC U
SIGNATURE OF PHYSICIAN OR SUPPLIER 22 SERVICE	YES NO	\$ \$
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	E FACILITY LCCATION INFORMATION	33 BILLING PROVIDER INFO & PH # (
apply to this bit and are made a part flereof)		
ONED DATE	b.	b.



PICA								PICA
MEDICARE MEDICARE (Medicare#) (Medicaid#		CHAMPVA (Member/D#)	GROUP HEALTH PLA (ID#)	N FECA	NG OTHER	1a. INSURED'S I D. NUMBER 0000010		(För Frögram in Item 1)
PATIENT'S NAME (Last Name	r, First Name, Middle Initial)		PATIENT'S BIRTH	DATE	SEX	4 INSURED'S NAME (Last Na	ne, First Name, I	Addie Initial)
Martha X Dan PATIENT'S ADDRESS (No., 8	and)	6	01 01 2	001 M	F X	martha X dan 7. INSURED'S ADDRESS (No.	Cheet)	
1 City Place, St Lo		ľ	Self X Spouse		Other	1 City Place, St lo	·	
TY St louis		STATE B	RESERVED FOR	NUCC USE		St Louis		STATE
PCODE	TELEPHONE (Include Area	Code)				ZIP CODE	TELEPHONE	(Include Area Code)
63021	(800)800-800	0				63021	(800) 800-8000
other insured's name (L Dan Martha	ast Name, First Name, Middle	thitial) 16	D. IS PATIENT'S CO	ONDITION REL	ATED TO:	11. INSURED'S POLICY GROUND GR	JP OR FECA NU	MEER
OTHER INSURED'S POLICY	OR GROUP NUMBER	a.	. EMPLOYMENT? (Current or Prev	40US)	a. INSURED'S DATE OF BIRTI		SEX
(12141 RESERVED FOR NUCC USE			YE AUTO ACCIDENT				. М	F
icos i i i i i i i i i i i i i i i i i i i			X YE		PLACE (State)	b. OTHER CLAIM ID (Designa	ted by NUCC)	
RESERVED FOR NUCCUSE		c.	OTHER ACCIDEN	π?		c. INSURANCE PLAN NAME C	OR PROGRAM N	AME
NSURANCE PLAN NAME OF	I DOCGO AM NAME	1.0	X YE			A IDTUEDE MODUES NEV	THE CONTEST OF	11/2
TOURNICE FLAN HAVE UP	TO DOGRAM HAME	11	Dd. CLAIM CCDES	(nesignated b)	(NOCC)	d IS THERE ANOTHER HEAL		MN7 Bitems 9, 9a, and 9d.
READ PATIENT'S OR AUTHORIZE	BACK OF FORM BEFORE (COMPLETING & authorize the rele	SIGNING THIS FO	RM. or other informa	tion necessary	13 INSURED'S OR AUTHORIZ	ED PERSON'S	
to process this claim. I also red below						services described below	i in the undersign	ed physician or supplier for
SIGNED			DATE Se	p 2 2019	•	SIGNED		
DATE OF CURRENT ILLNES	1 4	(LMP) 15. OTI	HERIDATE	MM DD	YY	16. DATES PATIENT UNABLE		PRENT OCCUPATION MAI DD YY
NAME OF REFERRING PRO	DAL WIDER OR OTHER SOURCE				1800 18	FRCM 18 HOSPITALIZATION DATES MM DD	TO RELATED TO 0	CURRENT SERVICES
		17b	NPI			FROM DD	то	MM DD YY
ADDITIONAL CLAIM INFOR	MATION (Designated by NUC	c)				20. CUTSIDE LAB?	\$ CF	IARGES
DIAGNOSIS OR NATURE OF	FILLNESS CR INJURY Rela	te A-L to ser wice	line below (24E)	ICD Ind		22. RESUBMISSION CODE	CRIGINAL RE	E NO
L	в [c L		Ð. 🗀		23. PRICE AUTHORIZATION		
1	F. L	G L		н І		23, PHICH ACT HCRIZATION	YUMBEH	
. A. DATE(S) OF SERVICE			JRES, SERVICES, (Unusual Orgumstar		E. DIAGNOSIS	F. G. DAYS	H. I. EPSOT ID	J. RENDERING
	DD YY SERVICE EMG			DIFIER	PCINTER	S S CHARGES UNITS	Family ID Ran QUAL	PROVIDER ID. #
		1					NPI	
	1 1 1	1	î l				NPI	
							NPI	700
							NPI	
			=4					
					1		NPI	WESSELSE
	111		1 1	1	1	1 1 1	NPI	
FEDERAL TAX LD NUMBER	3 55N EN 26	PATIENT'S ACC	COUNT NO	27 ACCEPT A	SSIGNMENT?	28 TOTAL CHARGE	9 AMOUNT PAI	0 30 Rsvd for NUCC U
SIGNATURE OF PHYSICIAN	TUB GIBBIES ~	DEDUICE EXCU	I ITV I CONTION IN	YES	МО	\$ 22 PH LING PROMPED INFO	\$ / DU# /	
INCLUDING DEGREES CR (I certify that the statements of apply to this bill and are made	CREDENTIALS on the reverse	SEMVIUE FACI	LITY LCCATION IN	POHMATION	2	33 BILLING PROVIDER INFO	am# ()
	a	NIDI	b	333		a NPI	b.	
GNED	DATE " available at www.nuc	20.000		PRINT OR	TVDE			197 FORM 1500 (02-



PICA					10000				PICA
. MEDICARE MEDIC		CHAMPV	- HEALTH	PLAN BLKL	JING	1a. INSURED'S I.D. NUME	ER	(For	Program in Hem 1)
(Medicare#) (Medicare#) (Medicare#)	<u> </u>	(Member IE	B PATIENT'S	((0.4)	(101)	879777815 4. INSURED'S NAME (Lass	Maria Par		Total III
Wozzer, Erik, C	aste, riist Naitte, Middle Mil	idi)	06 12	1 YY	SEX F	Wozzer, Samm		iname, Mode	mila)
PATIENT'S ADDRESS (No	, Street)			LATIONSHIP TO I		7. INSURED'S ADDRESS			
123 Anystreet Di	r.		Self Sp	oouse Child X	Other	123 Anystreet I	Dr.		
ITY		1	8 RESERVED	FOR NUCC USE		CITY			STATE
Gotham	TELEPHONE (Indude	AR				Gotham	1		AR
12345	(604) 175-2					12345	1181	EPHCNE (Indu (555) 72	
	(004) 173-2 E (Last Name, First Name, fi		10. IS PATIENT	'S CONDITION RE	LATED TO	12343 11. INSURED'S POLICY G	BOUP OB F	· /	
						AR761MNZ34			
OTHER INSURED'S POLICE	CY OR GROUP NUMBER		a. EMPLOYME	NT? (Current or Pre	Mous)	a. INSURED'S DATE OF E	ІВТН		SEX
			×		NO	15 20	1901	MX	F
RESERVED FOR NUCC L	JSE		b. AUTO ACCI		PLACE (State)	b. OTHER CLAIM ID (Desi	gnated by N	UCC)	
RESERVED FOR NUCCU	95		c. OTHER ACC	YES	NO []	c. INSURANCE PLAN NAM	45.00.000	CO AND NAME	
					NO	Great Plans	as on mo	CE TAMES BANGES	
INSURANCE PLAN NAME	OR PROGRAM NAME		_	DES (Designated b		d. IS THERE ANOTHER H	EALTH BEN	EFIT PLAN?	
						YES X NO	Hyes,	complete items	s 9, 9a, and 9d
	AD BACK OF FORM BEFO				ation necessary	13. INSURED'S OR AUTH			
	request payment of government					services described belo		macraighta ph	yadara aappero
SIGNED			DATE			SIGNED			
DATE OF CURRENT ILL	NESS, INJURY, or PREGNA	NCY (LMP) 15.	THER DATE			16. DATES PATIENT UNA	BLETOWO	AK IN CUARE	NT OCCUPATION
12 13 2019	QUAL -	QU.	AL	MM DD	ΥΥ	FROM 9 27	2019	™ 05	27 2050
NAME OF REFERRING F	PROVIDER OR OTHER SO	URCE 17a				18 HOSPITALIZATION DA	TES RELAT	ED TO CURRE	
Anoter Perso		Laborate Contract Con	NPI			FROM		TO	
, ADBITIONAL CLAIMINE	ORMATION (Designated by	NOCC)				20 OUTSIDE LAB? X YES NO		\$ CHARGE 2500	
I. DIAGNOSIS OR NATURI	E OF ILLINESS OF INJURY	Refalle A-L to servi	ce line below (24	IE) ICD Ind.		22. RESUBMISSION CODE	, CRIC	SINAL REF. NO)
<u> </u>	В	_ c.L		- b L		12687 23. PRICE AUTHORIZATION	<u>4</u>	3	
	F. L	_ G L		. н.		12FB789	GT TONDE	1	
4. A. DATE(S) OF SEF				CES, OR SUPPLIES		F.	G. H.	I.	J.
From M DD YY MM	To PLACE OF DD YY SERVICE	EMG CPT/HCP	n Unusual Circu CS	mstances) MODIFIER	DIAGNOSIS POINTER	S CHARGES L	OR Family	ID. QUAL.	RENDERING PROVIDER ID. #
1 1 1		1				1			
						! !		NPI	
1 1 1	1 1 1 1		1		1			NPI	
							- 47		(Blockets
								NPI	
A CONTRACTOR OF THE PARTY OF TH	1 1 1 1		-			1			
								NPI	
1 1 1	1 1 1 1			1 1		1 1		NO	
							11-6	NPI	
							1	NPI	
FEDERALTAXID NUM		26 PATIENTS	COUNT NO	27 ACCEPT For govt cli	ASSIGNMENT?	28 TOTAL CHARGE	29 AMC	UNT PAID	30. Rsvd for NUCC U
342-768-32	x			YES	МО	\$	\$		
1 SIGNATURE OF PHYSIC INCLUDING DEGREES (I certify that the statement apply to this bill and are r	CR CREDENTIALS nts on the reverse	32 SERVICE FA	CILITY LOCATIO	ON INFORMATION		33 BILLING PROVIDER II	NFO & PH#	()	
GNED	DATE	a hii	b.			a: NPI	b.		
						The state of the s	-	-	OF REAL PROPERTY.



PICA	2011-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0		AND DESCRIPTION					PICA
1 MEDICARE MEDIC		CHAMPVA	HEALTH PLAN	ELKLUNG _	_	1a INSURED'S LO NUMBER		(For Frogram In Item 1)
(Medicares) (Medic		(Member ID		(102)	(10#)	13371337		
2 PATIENT'S NAME (Last No Leclerc, Charles	ame, Hrst Name, Madde Inili	at)	3 PATIENT'S BIRTH (YY —	F	4 INSURED'S NAME (Last Nam Leclerc, Charles	ne, First Name, Mi	date Initial)
5 PATIENT'S ADDRESS (No	, Street)		6 PATIENT RELATICE	THE R. P. LEWIS CO., LANSING, MICH. LANSING, MICH.		7 INSURED'S ADDRESS (No.	Street	
280 Washington	St		Self X Spouse	Child Ot	ner 🗍	777 Brockton Ave		
CITY			8 RESERVED FOR N	UCC USE		СПУ		STATE
Hadseb		MA	Ž.			Abington		MA
ZIP CODE	TELEPHONE (Induda					ZIP CODE		Include Area Code)
01749	(123) 456 7			IDITION DELL'ATTEND	70	02351		0987654
OTHER INSURED'S NAME	= (Last Name, First Name, N	icole initial)	10 IS PATIENT'S CON	NUMBERATED	10.	11, INSURED'S POLICY GROU 123123123	POHFECANUM	BEH
OTHER INSURED'S POLI	CY OR GROUP NUMBER		a EMPLOYMENT? (O	urrent or Previous)		a INSURED'S DATE OF BIRTH	1	SEX
			YES	NO		10 10 97	M >	₹ F
RESERVED FOR NUCC U	ISE		b. AUTO ACCIDENT?	PLAC	CE (State)	b. OTHER CLAIM ID (Designat		
			YES	NO L				
. RESERVED FOR NUCC U	SE		c. OTHER ACCIDENT			C INSURANCE PLAN NAME O	R PROGRAM NAI	VE.
I INSURANCE PLAN NAME	00.000000000000000000000000000000000000		YES		~			16.
I MOUNANUE MLAN NAME	On PROGRAM NAME		10d. CLAIM CODES (D	Jesignated by NUC	C)	d IS THERE ANOTHER HEALT		items 9, 9 a, and 9d
ne ne	AD BACK OF FORM BEFO	RE COMPLETING	A SIGNING THIS FOR	M.		13 INSURED'S OR AUTHORIZ	- 7	
2 PATIENT'S OR AUTHOR to process this claim. I also	IZED PERSON'S SIGNATU request payment of government	RE I authorize their	elease of any medical or	other information ne		payment of medical benefits services described below		
below								
SIGNED			DATE U9/	27/19		SIGNED	<u> </u>	
4 DATE OF CURRENT ILLI	NESS, INJURY, or PREGNA	100	OTHER DATE	M DD YY		16 DATES PATIENT UNABLE	TO WORK IN OUR	RRENT OCCUPATION
	CUAL.	1005				FROM	TO TO CO	IDDOLLE CODENOCO
7. NAME OF REFERRING F	THOVIDER OF CITIEN SO		NPI			18 HOSPITALIZATION DATES MM DD FROM	TO	MM DD YY
9 ADDITIONAL CLAIM INF	ORMATION (Designated by		146-1			20 CUTSIDE LAB?		RGES
						YES NO		1
21 DIAGNOSIS OR NATUR	E OF ILLNESS OF INJURY	Relate A-L to servi	ce line below (24E)	ICD Ind !		22 RESUBMISSION CODE	COLCULAR DES	. 110
A L	в	c L		D L		CODE	CRIGINAL REF	· NU
E	F L	G L		н		23 PRICE AUTHORIZATION N	IUMBER	
i. L	J. L	ĸ.L		_ L [
Prom A DATE(S) CF SEF	To SLACE OF	(Expta	DURES, SERVICES, CR in Unusual Circumstance	es) D	E. IAGNOSIS	F G DAYS	H. I EPSDT ID.	J. RENDÉRING
MM DD YY MM	DD YY SERVICE	EMG CPT/HCP	CS MODI	IFIER I	PONTER	\$ CHARGES UNITS	Farrey ID. Plan QUAL	PROVIDER ID.
1 1 1							NPI	
							NPI	
		1						
		1					NPI	
1 1 1	1 1 1 1		1 1	1 1 1		1 1		
							NPI	
1 1 1	1 1 1	1	1 1				NPI	
							14-1	
				1			NPI	
25 FEDERALTAXID NUM	BER SSN BN	26. PATIENT'S A	ACCOUNT NO 2	7 ACCEPT ASSIG	NMENT?	28 TOTAL CHARGE 2	9 AMOUNT PAID	30 Rsvd for NUCC Usi
				YES N			\$	
31 SIGNATURE OF PHYSIC INCLUDING DEGREES		32 SERVICE FA	CILITY LOCATION INF	CRMATION		33 BILLING PROVIDER INFO	8 PH# ()
(I cerlify that the statemen apply to this bill and are n								
	1520							
EIGNED	0.75	a 5/16	h.			a NPI	1	
SIGNED	DATE							



PICA MEDICARE MED	ICAID TRICARE	CHAMPVA	GPOLE	FECA	Office	1a INSURED'S LD NUMBER	4 (6	PICA Frogram in Item 1)
	cald#) [[] (ID#/DoD#)	(Mamber ID#)	GROUP HEALTH PLAN (104)	EE SA	(104)	23411	. ,	or riogrammizin iy
PATIENT'S NAME (Last I) Alex Friday	lame, First Name, Midde Inite	i) 3	01 01 20)01 M	F X	4 INSURED'S NAME (Last N Alex Friday		de Initial)
PATIENT'S ADDRESS (N 1 Road	io, Steet)	6	PATIENT RELATION	Child Child	Other	7 INSURED'S ADDRESS (No. 1 Road	o., Steet)	
oxtown		FL	RESERVED FOR N	UCC USE		Coxtown		STATE FL
CODE	TELEPHONE (Indua)					ZIP CODE	4 4	clude Area Code)
000	(414) 515 6					6000		515 6161
JTHER INSURED'S NAN	IE (Last Name, First Name, M	code initiar) 11	O IS PATIENT'S CON	IDITION HELAT	ED 10	11 INSURED'S POLICY GRO	JUP OH FECA NUMB	EH
OTHER INSURED'S POL	JCY OR GROUP NUMBER	а	. EMPLOYMENT? (O		15)	a INSURED'S DATE OF BIR		SEX
RESERVED FOR NUCC	USÉ	b	YES AUTO ACCIDENT?		LACE (State)	01 01 20	IO1 M aled by NUCC)	FX
	SURF.		YES	· ·	LACE (Sidie)		2	
RESERVED FOR NUCC	USE	C	OTHER ACCIDENT			C. INSURANCE PLAN NAME	CA PROGRAM NAM	E
NSURANCE PLAN NAM	E OR PROGRAM NAME	11	Od CLAIM CCDES (UCC)	d ISTHERE ANOTHER HEA	LTH BENEFIT PLANS	
-	CAN DANK OF FORM OFFICE	DE COMPLETATO *	DIONING THEFOR	44		YES NO	#yes, complete ite	
PATIENT'S CR AUTHO	EAD BACK OF FORM BEFOR RIZED PERSON'S SIGNATUR so request payment of government	El fauthorize the rele	ease of any medical or	other information		13 INSURED'S OR AUTHOR payment of medical benef services described below		
SIGNED			09/	26/2019		SIGNED		
DATE OF CURRENT ILL	LNESS, INJURY, or PREGNA	ICY (LMP) 15 OT	HER DATE	M DD	YY	16 DATES PATIENT UNABL MM DD FRCM	E TO WORK IN CUR!	RENT OCCUPATION M DD YY
NAME OF REFERRING	PROVIDER OF OTHER SOU					18 HOSPITALIZATION DATE	S RELATED TO CUP	RENT SERVICES M DD YY
		17b	NPI			FROM DD	10	M DO 11
ADDITIONAL CLAIM IN	FORMATION (Designated by I	(UCC)				20 OUTSIDE LAB?	\$ CHAF	RGES
DIAGNOSIS OR NATUR	REOFILLNESS OR INJURY I	Relate A-L to service	line below (24E)	ICD Ind		22 RESUBMISSION CODE	CRIGINAL REF.	ио
	8 L	. CL . GL.		р <u>Г</u>		23 PRICE AUTHORIZATION	NUMBER	
<u> </u>	J. [К. L		<u> </u>				
A DATE(S) CF SE From M DD YY MA	To PLACEOF	(Explain	URES, SERVICES, OF Unusual Circumstanc MOD	es)	DIAGNOSIS PCINTER	F G DAY CF S CHARGES UNIT	H I S FETOT ID S Flan QUAL	J RENDERING PROVIDER ID. #
			T				NPI	
× 141-								
		840					NPI	
					1		NPI	
111							NPI	
	1 1 1							
							NPI	
							NPI	
FEDERALTAXID NU	MBÉR SSNÉN	26 PATIENT'S AC	COUNT NO 2	7 ACCEPT ASS For pove claims	SIGNMENT? L'SEE BLOS)	28 TOTAL CHARGE	29 AMOUNT PAID	30. Risvd for NUCC U
SIGNATURE OF PHYS INCLUDING DEGREES (I certify that the statem apply to this bill and are	CR CREDENTIALS ents on the reverse	32 SERVICE FACE	LITY LOCATION INF		1	33 BILLING PROVIDER INF)
CNED	DATE	a	b.			a NP	b.	
GNED	DATE		21.51.25.5	DIAIT OF T	upe	-	Trade page 146	97 FCRIM 1500T02



MED CARE MED		CHAMPVA	GROUP HEALT	H PLAN		1a INSURED'S I D. NUMBER	(For Program In Hern 1)
(Medicare#) (Medic PATIENT'S NAME (Last N Radish, Josie, K	ame, First Name, Middle Ini	(Member IDA	9 (10#) 9 PATIENTS! 9 17	BIRTH DATE	SEX	4 INSURED'S NAME (Last Name, First Name) Anthem	ne, Middle Initial)
PATIENT'S ADDRESS (NO. 1117 Cleveland.				Dati CNSH:P		7 INSURED'S ADDRESS (No., Skeet) 1100 Michigan Ave	
ry cirkwood		STATE I	B RESERVED	FOR NUCC U	SE	СПҮ Purchase	STATE
CODE	TELEPHONE (Indud					ZIP CODE TELEPH	CNE (Indude Area Code)
3122	(314) 800-		IN IS PATIENT	rs condition	N RELATED TO:	11 INSURED'S POLICY GROUP OR FECA	ANIMPER
liller, Nancy M	E (Cast (varie, nist (varie, i	sidule sistary	IO IS FAILEN	3 001011101	THEORIED TO:	TI, INSURED & POLICE GROUP ON PECA	HOWER
THER INSURED'S POLI M01761A	CY OR GROUP NUMBER		a EMPLOYME	NT? (Current o	_	a INSURED'S DATE OF BIRTH	SEX
ESERVED FOR NUCC I	USE		b. AUTO ACCI		NO PLACE (State	b OTHER CLAIM ID (Designated by NUCC	M F
			>	YES [NO MI		
ESERVED FOR NUCC (ISE		COTHER ACC		V 110	c. INSURANCE PLAN NAME OF PROGRA Sunshine Health	MINAME
SURANCE PLAN NAME	OR PROGRAM NAME		10d CLAIM CO	YES DES (Designa	X NO	d is there another health benefit	PLAN?
				THE SECTION		YES NO Hyes com	plete items 9, 9a, and 9d
PATIENT'S OR AUTHOR	AD BACK OF FORM BEF IZED PERSON'S SIGNATU	IRE authorize the re	lease of any me	edical or other in			
o process this claim. I also Delow	a request payment of govern	ment benefits either to	•	· -		services described below	.,
IGNED			DATE	9/18/19		SIGNED	
ATE OF CURRENT ILL	NESS INJURY OF PREGN	ANCY (LMP) 15 O	THER DATE	мм с	אין סכ	16 DATES PATIENT UNABLE TO WORK I	
IAME OF REFERRING	CUAL PROVIDER OR OTHER SO				1	FRCM 18 HOSPITALIZATION DATES RELATED TO THE PROPERTY OF THE	TO CURRENT SERVICES
		17b	NP				TO DD YY
ADDITIONAL CLAIM INF	ORMATION (Designated by	(NUCC)				20 CUTSIDE LAB?	\$CHARGES
DIAGNOSIS OF NATUR	E OF ILLNESS CA INJURY	Relate A-L to service	e line below (2	E) ICD Inc		22 RESUBMISSION CRIGINA	L REF NO.
	8 L	_		- 0	<u> </u>	23 PRICE AUTHORIZATION NUMBER	DE L'ANDRAGE
	F;	_ G i_ _ K _		_			
A DATE(S) OF SET From DD YY MM	To FLACEOF	(Explain	Unusual Circu	CES, CR SUPF irnstances) MODIFIER	DIAGNOS POINTE) RENDERING
4 19 4	5 18	ASK	1			750 99 N	1740985321
					1 1	NF NF	0
					1 1	I N	ot
1 1 1					1 1	1 1 1	
					1	! NF	1
						N.	ગ
						N N	7
FEDERALTAX I D NUN	BEA SSN EIN	26 PATIENT'S AC	CCOUNT NO		EPT ASSIGNMENT		PAID 30 Rsvd for NUCC
SIGNATURE OF PHYSIC INCLUDING DEGREES It certify that the stateme apply to this bill and are:	CR CREDENTIALS nts on the reverse	32 SERVICE FAC	DILITY LOCATI	ON INFORMAT	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	\$ \$ 33 BILLING PROVIDER INFO & PH # ()
		a	lh.			a NPI b	
SNED	DATE Jual available at www			SE PRINT		APPROVED CMB-093	



PICA			PICA TITLE
1 MEDICARE MEDICAID TRICARE CHAMPV (Medicard#) (Medicaid#) (ID#/DoD#) (Member It	- HEALTH PLAN - BLK LUNG -	1a INSURED'S I D NUMBER (For Frogra 23435023	am in Hem 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 Inlial)	
Jone, Mary L 5 PATIENT'S ADDRESS (No., Steet)	03 19 70 M F X	Jones, Mary L 7 INSURED'S ADDRESS (No., Street)	
42713 Steety Dr	Self X Spouse Child Other	42713 Steety Dr	
Springfield MA	B RESERVED FOR NUCC USE	CITY Springfield	STATE
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Are	a Code)
65432 (213) 555-1145		65432 (213)55511	MA Pa Code) 145
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 123454567	
OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX	
- penenuen consultor uce	YES X NO	03 19 7O ML	FX
b. RESERVED FOR NUCC USE	D AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM (D (Designated by NUCC)	
RESERVED F.CR NUCC USE	c OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	
<u> </u>	YES X NO	MyHomestate Health	meru e
d. Insurance Plan Name or Program Name	10d CLAIM CCDES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO #yes complete items 9, 9a,	100
READ BACK OF FORM BEFORE COMPLÉTING 12 PATIENT'S CR AUTHORIZED PERSON'S SIGNATURE I authorize the	3 & SIDNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Lauthorize
to process his claim. I also request payment of government benefits a ther below		payment of medical benefits to the undersigned physician services described below	or supplier for
SIGNED	DATE	SIGNED	
MM + DD + YY	OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CURRENT OF	CUPATION
01 02 19 OUAL 17:	AL	FROM TO 18 HOSPITALIZATION DATES RELATED TO CURRENT SE	
1	NP)	FROM DD YY MM DD	YY
9 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? \$CHARGES	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	ge line below (24E)	YES NO	
A [k35.2 B CL	ICD Ind	22 RESUBMISSION CRIGINAL REF. NO.	2
E.L. FL. GL	н	23 PRICE AUTHORIZATION NUMBER	111 - 1411 (2222)
1	DURES, SERVICES, OR SUPPLIES E.	F G H I	J
	in Unusual Circumstances) DIAGNOSIS	DAYS FPOT ID RE	NDERING WIDER ID #
01 02 19 01 05 19		419 39 3 NPI 12453195	
		12,00	
		NPI	
		l NPI	
		NPI	
		Np1	
25 FEDERALTAX I.D NUMBER SSN EIN 26 PATIENT'S	ACCOUNT NO. 27 ACCEPT ACCICABATE TO	28 TOTAL CHARGE 29 AMOUNT PAID 30 F	Rsvd for NUCC Use
20 PATIENTS	ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For govt classes, see back) YES NO	\$ S	asid for NUCCUSE
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE F.	CILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH # ()	
() certify that the statements on the reverse apply to this bit and are made a part thereof)		15.1	
		73757	
SIGNED DATE	b	a b.	