# 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): BR549

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hunt, Ethan, S

3. PATIENT'S BIRTH DATE: 09 | 11 | 1990 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Hunt, Ethan S.

5. PATIENT'S ADDRESS (No., Street): 117 St. Clair St.

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

7. INSURED'S ADDRESS (No., Street): 117 St. Clair St.

CITY: Glendale STATE: TX

8. RESERVED FOR NUCC USE

CITY: Glendale STATE: TX

ZIP CODE: 76158 TELEPHONE (Include Area Code): ( 314 ) 867-5309

ZIP CODE: 76158 TELEPHONE (Include Area Code): ( 314 ) 867-5309

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: FY832IG0893

a. OTHER INSURED'S POLICY OR GROUP NUMBER: n/a

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

a. INSURED'S DATE OF BIRTH: 09 | 11 | 1990 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): n/a

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Insurance 'R US

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 _____ 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): 09 | 11 | 2019 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 09 | 11 | 2019 TO 09 | 27 | 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Brian Smith

17a

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 09 | 11 | 2019 TO 09 | 13 | 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 9999.00

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

A. Head Tra
B. Broken F
C. Broken F
D.
E. Broken Ul
F. Broken Ul
G.
H.
I.
J.
K.
L.

22. RESUBMISSION CODE: OU812 ORIGINAL REF. NO.: WTF73

23. PRIOR AUTHORIZATION NUMBER: BS123

| 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.)

9/26/19
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 (Medicare#) | MEDICAID [X] (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): 316kh87

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mars, Veronica R

3. PATIENT'S BIRTH DATE: 03 | 15 | 92 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Mars, Keith L

5. PATIENT'S ADDRESS (No., Street): 4482 Jefferson St Apt 23

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

7. INSURED'S ADDRESS (No., Street): 4482 Jefferson St Apt 23

CITY: Neptune | STATE: CA

8. RESERVED FOR NUCC USE

CITY: Neptune | STATE: CA

ZIP CODE: 87155 | TELEPHONE (Include Area Code): ( 878 ) 5483257

ZIP CODE: 87155 | TELEPHONE (Include Area Code): ( 878 ) 8724872

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: jrtr872

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 10 | 31 | 69 SEX: M [X] 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: Neptune HealthCare

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: Veronica Mars DATE: 8/12/03

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: Keith Mars

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 07 | 12 | 2013 QUAL: fine

15. OTHER DATE QUAL: MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 05 | 11 | 2018 TO 02 | 08 | 2020

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Will Grace

17a. [ ] 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 06 | 13 | 2008 TO 03 | 22 | 2012

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 1000.01

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

A. E00-E90 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 | 09 | 12 | 00 | 09 | 25 | 00 | ER | 11 | 99213 | 21 | | 0.94 | | | NPI | 1245319599 |
| 2 | | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 326879832 SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: tL66ku8

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

28. TOTAL CHARGE: $ 0.94

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION
84357 Stacy Rd
Springfield, OR
79845
a. NPI b.

33. BILLING PROVIDER INFO & PH #: ( 654 ) 5579816
Candy Cane Loop
North Pole, LA
67662
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 (Medicare#) | MEDICAID [X] (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): O576444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Finn, Nemo B

3. PATIENT'S BIRTH DATE: 08 16 03 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Finn, Merlin s

5. PATIENT'S ADDRESS (No., Street): 42 Wallaby Way

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

7. INSURED'S ADDRESS (No., Street): 42 Wallaby Way

CITY: Sydney | STATE: AL

8. RESERVED FOR NUCC USE

CITY: Sydney | STATE: AL

ZIP CODE: 59876 | TELEPHONE (Include Area Code): (231) 1234567

ZIP CODE: 59876 | TELEPHONE (Include Area Code): (231) 1234567

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? YES [ ] NO [ ]

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: RE351414

a. INSURED'S DATE OF BIRTH: 05 04 88 SEX: M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: Deep Sea Health

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: Nemo Finn DATE: 05/17/18

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: Merlin Finn

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 21 06 QUAL: bad

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 02 09 08 TO 02 15 10

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dre Young

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 02 28 12 TO 04 06 14

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

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 | 12 5 99 | 02 08 00 | 11 | 55 | 99213 | 21 | | | | 305 88 | | | NPI | |
| 2 | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 487-89-4578 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 357634

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

28. TOTAL CHARGE: $ 2152.68

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION
825 Ocean Dr
Pacific, OR 43267
a. NPI b.

33. BILLING PROVIDER INFO & PH #: (587) 4578962
712 Coral Rd
Waterfall, AK 44573
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 (Medicare#) | MEDICAID [X] (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): 316354Y32

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Holms, Phillip, T

3. PATIENT'S BIRTH DATE: 02 | 28 | 70 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Holms. Phillip, T

5. PATIENT'S ADDRESS (No., Street): 888 Strawberry Lane

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

7. INSURED'S ADDRESS (No., Street): 888 Strawberry Lane

CITY: Paris | STATE: MO

8. RESERVED FOR NUCC USE

CITY: Paris | STATE: MO

ZIP CODE: 65812 | TELEPHONE (Include Area Code): ( 680 ) 8005430

ZIP CODE: 65812 | TELEPHONE (Include Area Code): ( 680 ) 8005430

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? YES [ ] NO [ ]

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: G657

a. INSURED'S DATE OF BIRTH: 02 | 28 | 70 SEX: M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross

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: Phil Holms DATE: 7/28/09

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: Phil Holms

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 05 | 08 | 2000 QUAL: bad

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 05 | 08 | 2000 TO 05 | 08 | 2000

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

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 04 | 12 | 2000 TO 04 | 12 | 2000

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

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

A. E00-E90 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 | 09 | 12 | 00 | 09 | 25 | 00 | ER | 11 | 99213 | 21 | | 82.78 | | | NPI 1245319599 |
| 2 | | | | | | | | | | | | | | | NPI |
| 3 | | | | | | | | | | | | | | | NPI |
| 4 | | | | | | | | | | | | | | | NPI |
| 5 | | | | | | | | | | | | | | | NPI |
| 6 | | | | | | | | | | | | | | | NPI |

25. FEDERAL TAX I.D. NUMBER: 321876845 SSN EIN

26. PATIENT'S ACCOUNT NO.: tLKASD

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

28. TOTAL CHARGE: $ 82.78

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION

53547 Lurry Lane

Chicago, IL

84873

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( 653 ) 3543248

Doo Bop Circle

Boston, PA

42588

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 (Medicare#) | MEDICAID [X] (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): TA48769

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rapper, Chance T

3. PATIENT'S BIRTH DATE: 05 04 88 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Rapper, Chance, T

5. PATIENT'S ADDRESS (No., Street): 100 Michigan Ave

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

7. INSURED'S ADDRESS (No., Street): 100 Michigan Ave

CITY: Chicago | STATE: IL

8. RESERVED FOR NUCC USE

CITY: Chicago | STATE: IL

ZIP CODE: 45686 | TELEPHONE (Include Area Code): (309) 8572365

ZIP CODE: 45686 | TELEPHONE (Include Area Code): (309) 8572365

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: G88725

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 05 04 88 SEX: M [X] 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: Chicagoian

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: Chance The Rapper DATE: 11/18/05

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: Chance The Rapper

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 08 03 92 QUAL: bad

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 02 09 93 TO 02 15 93

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dre Young

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 02 28 93 TO 04 06 93

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0.00

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 | 12 5 99 | 02 08 00 | 11 | 55 | 99213 | 21 | | | | 1 00 | | | NPI | |
| 2 | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 458-78-8877 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 54967026

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

28. TOTAL CHARGE: $ 2.01

29. AMOUNT PAID: $ 2.01

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: 15 8Th Ave, New Berlin, MO 65894

a. NPI: b.

33. BILLING PROVIDER INFO & PH #: (618) 7894561

88 Good Place, Eleanor, CA 78453

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 ☐ (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): 23435023

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jone, Mary L

3. PATIENT'S BIRTH DATE: 03 19 70 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Jone, Mary L

5. PATIENT'S ADDRESS (No., Street): 42713 Steety Dr

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 42713 Steety Dr

CITY: Springfield STATE: MA

8. RESERVED FOR NUCC USE

CITY: Springfield STATE: MA

ZIP CODE: 65432 TELEPHONE (Include Area Code): (213) 555-1145

ZIP CODE: 65432 TELEPHONE (Include Area Code): (213) 5551145

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123454567

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH: 03 19 70 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: MyHomestate Health

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 _____ 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): 01 02 19 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. k35.2 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 01 | 02 | 19 | 01 | 05 | 19 | | | | | | 419 39 | 3 | | NPI | 1245319599 |
| 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

# 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): PDEA87654321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SOLERA CHRISTIE R.

3. PATIENT'S BIRTH DATE: 01 02 03 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FARGINI, LUCA

5. PATIENT'S ADDRESS (No., Street): 7788 Bradill Ave.

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

7. INSURED'S ADDRESS (No., Street): 323 Zucchini Rd.

CITY: Rockvale | STATE: CO

8. RESERVED FOR NUCC USE

CITY: Ripton | STATE: VT

ZIP CODE: 81226 | TELEPHONE (Include Area Code): (711)721-3743

ZIP CODE: 05766 | TELEPHONE (Include Area Code): (621)315-2719

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 617221

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 723123

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

a. INSURED'S DATE OF BIRTH: 06 21 65 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE: COD-21720

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE: NEW1315AB

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA PLATINUM PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME: PBC PPO/TRADE

10d. CLAIM CODES (Designated by NUCC): 74-15-BCF2

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: 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 11 01 18 QUAL: 3A

15. OTHER DATE: QUAL: B 02 01 71

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

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

17a

17b. NPI: TORONTO

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Never took aspirine

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: $213

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A F107 B A12.3 C H60.1 D N13.2
E R23.2 F S12.018A G A04.7 H L42
I F02.80 J M12.01 K F81 L J23

22. RESUBMISSION CODE: | ORIGINAL REF. NO.: 123-123

23. PRIOR AUTHORIZATION NUMBER: 2117018198RA

| 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 11 03 18 | 11 03 18 | CO | A | L0160 | | 1 | 640 00 | 1 | | NPI | 3687422491 |
| 2 11 04 18 | 11 04 18 | CO | A | L0170 | | 1 | 740 50 | 1 | | NPI | 6183154267 |
| 3 11 07 18 | 11 07 18 | CO | A | L1812 | | 2 | 865 00 | 1 | | NPI | 7289243212 |
| 4 11 15 18 | 11 15 18 | CO | B | L1836 | | 1 | 1630 50 | 1 | | NPI | 6394213229 |
| 5 11 21 18 | 11 21 18 | NM | A | L1907 | | 1 | 126030 | 1 | | NPI | 6132274921 |
| 6 12 13 18 | 12 13 18 | NM | B | L2005 | | 2 | 12020 | 1 | | NPI | 2154299286 |

25. FEDERAL TAX I.D. NUMBER: 123-456-7890 SSN EIN [ ]

26. PATIENT'S ACCOUNT NO.: 98765432 1

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

28. TOTAL CHARGE: $19,513.23

29. AMOUNT PAID: $ 765 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: 12-1-18

32. SERVICE FACILITY LOCATION INFORMATION: Boston, MA

a. NPI b.

33. BILLING PROVIDER INFO & PH# ( ): CSG-A271315

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): ZGX123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MARTIN, ALFREDO P.

3. PATIENT'S BIRTH DATE: 09 08 92 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ROMO, SERGEI H.

5. PATIENT'S ADDRESS (No., Street): 7007 TAMPICO Rd.

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

7. INSURED'S ADDRESS (No., Street): 300 Franken Fries St

CITY: Telecote STATE: NM

8. RESERVED FOR NUCC USE

CITY: Casper STATE: WY

ZIP CODE: 88318 TELEPHONE (Include Area Code): (612)313-2101

ZIP CODE: 82601 TELEPHONE (Include Area Code): (211)768-2169

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 227175

b. RESERVED FOR NUCC USE: 19-COS-723

c. RESERVED FOR NUCC USE: H23-2

d. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA PTX CHOICE

10. IS PATIENT'S CONDITION RELATED TO:

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

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

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

10d. CLAIM CODES (Designated by NUCC): BC-73-A18

11. INSURED'S POLICY GROUP OR FECA NUMBER: 441772

a. INSURED'S DATE OF BIRTH: 08 13 82 SEX: M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: Coventry PPO

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

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.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED: [signature] DATE: 9/7/19

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): 11 02 18 QUAL: 323

15. OTHER DATE: QUAL: 11 02 70

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 10 01 18 TO 10 03 18

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

17a.

17b. NPI: NEWARK

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 10 01 18 TO 10 02 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PBB745-19

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: $1120

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 10

A. G308 B. L23 C. R13.9 D. J13
E. F13 F. T01.19 G. N31.2 H. A38.3
I. G21.1 J. T88.9XA35 K. Z43.21 L. G23.21

22. RESUBMISSION CODE: ORIGINAL REF. NO: 223A12

23. PRIOR AUTHORIZATION NUMBER: 19B7A12L467

| 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 18 | 10 01 18 | NM | B | B4087 | | 1 | 240 00 | 1 | | NPI | 1234567891 |
| 2 10 03 18 | 10 03 18 | NM | A | B4154 | | 1 | 320 15 | 1 | | NPI | 2253427218 |
| 3 10 15 18 | 10 15 18 | NM | - | B4159 | | 1 | 245 25 | 1 | | NPI | 2166780228 |
| 4 10 20 18 | 10 20 18 | NM | C | B4185 | | 2 | 850 00 | 1 | | NPI | 9237428231 |
| 5 11 13 18 | 11 13 18 | NM | B | B9002 | | 1 | 420 10 | 1 | | NPI | 2123243157 |
| 6 11 18 18 | 11 18 18 | NM | A | B9006 | | 2 | 1220 50 | 1 | | NPI | 7286738902 |

25. FEDERAL TAX I.D. NUMBER: 987-654-3210 SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO: 37562152I

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

28. TOTAL CHARGE: $98,415.13

29. AMOUNT PAID: $2673.12

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: [signature] DATE: 11/17/18

32. SERVICE FACILITY LOCATION INFORMATION: Atlanta, GA

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

ICOMS A13551

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

PICA

CARRIER

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): ZGN000123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ORTEGA, LAURA T.

3. PATIENT'S BIRTH DATE: 12 | 13 | 69 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ORTEGA, LAURA T.

5. PATIENT'S ADDRESS (No., Street): 9654 Sadness St.

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

7. INSURED'S ADDRESS (No., Street): 9654 Sadness St.

CITY: Shandon STATE: CA

8. RESERVED FOR NUCC USE

CITY: Shandon STATE: CA

ZIP CODE: 93461 TELEPHONE (Include Area Code): (213) 323-1515

ZIP CODE: 93461 TELEPHONE (Include Area Code): (213) 323-1515

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

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER: 729512

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 8754981

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

a. INSURED'S DATE OF BIRTH: 12 | 13 | 69 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE: 18-BAPD-151

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE: BB8-R2D2

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBS of California

d. INSURANCE PLAN NAME OR PROGRAM NAME: BCBS MASS PPO

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: L. Ortega DATE: 6/13/19

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): 12 | 01 | 18 QUAL: DN

15. OTHER DATE QUAL: 12 | 07 | 18

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 07 | 09 | 18 TO 01 | 13 | 19

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

17a

17b. NPI: REDUX

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 08 | 22 | 18 TO 08 | 26 | 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Secondary insurance

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: $765

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: 10

A: PST B: L51 C: K23.1 D: O02.1
E: Z12.11 F: A06.8 G: J42 H: G21.0
I: C31.21 J: H42.102 K: K13.2 L: D61.7

22. RESUBMISSION CODE: B2 ORIGINAL REF. NO.: 2113797

23. PRIOR AUTHORIZATION NUMBER: SP71745678A

| 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 18 | 10 03 18 | CA | A | G0180 | | 2 | 200 00 | 3 | | NPI | 2123456789 |
| 2 10 4 18 | 10 07 18 | CA | - | G0181 | | 2 | 1,850 | 25 | 3 | NPI | 2123456789 |
| 3 10 15 18 | 10 18 18 | CA | B | G0182 | | 2 | 3620 00 | 3 | | NPI | 2123456789 |
| 4 11 07 18 | 10 07 18 | CA | A | G0162 | | 2 | 755 00 | 1 | | NPI | 3123123121 |
| 5 11 05 16 | 11 05 18 | CO | A | M0300 | | 3 | 125 | 25 | 1 | NPI | 2137427818 |
| 6 12 01 18 | 12 01 18 | CO | A | Q0492 | | 3 | 450 00 | 1 | | NPI | 7804772213 |

25. FEDERAL TAX I.D. NUMBER: 999-998-1234 SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345678

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

28. TOTAL CHARGE: $45,517.12

29. AMOUNT PAID: $824.01

30. Rsvd for NUCC Use: A20

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: L. Ortega DATE: 12/17/18

32. SERVICE FACILITY LOCATION INFORMATION: Memphis, TN

a. NPI b.

33. BILLING PROVIDER INFO & PH # (AB): CSG 1775

a. NPI b.

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): ABCd1234567890

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

3. PATIENT'S BIRTH DATE: 12 | 34 | 1956 SEX: M [✓] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Johnson, Jacob, Jingle

5. PATIENT'S ADDRESS (No., Street): 8765 Madeup St.

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

7. INSURED'S ADDRESS (No., Street): 1127 Veryfake rd.

CITY: New York STATE: NY

8. RESERVED FOR NUCC USE

CITY: Chicago STATE: IZ

ZIP CODE: 12345 TELEPHONE (Include Area Code): (816)527-8153

ZIP CODE: 76542 TELEPHONE (Include Area Code): (312)123-4567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Martin, Ricky, George

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: FECANUMB3R

a. OTHER INSURED'S POLICY OR GROUP NUMBER: ZYX987654321

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

a. INSURED'S DATE OF BIRTH: 07 | 18 | 1922 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): A12345678

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [✓] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: ACME Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME: Doesn't Exist Insurance

10d. CLAIM CODES (Designated by NUCC): CODE2

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: [signature] DATE: 05/16/2012

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): 12 | 12 | 2012 QUAL:

15. OTHER DATE: QUAL: 01 | 01 | 2001

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 06 | 14 | 1920 TO 07 | 18 | 1989

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Other Source

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 12 | 12 | 2012 TO 09 | 18 | 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): This is additional information

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 5000 | 00

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: ABC ORIGINAL REF. NO.: 12345278910

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 | 01 02 20 | 03 03 21 | A | ? | Not | | | 1000 | 25 | 5 | NPI | 12345678 |
| 2 | 02 11 15 | 04 04 22 | B | | sure | | | 2000 | 87 | 32 | NPI | 9101112134 |
| 3 | 03 12 18 | 05 16 23 | C | | what | | | 3356 | 22 | 83 | NPI | 15161789 |
| 4 | 04 13 06 | 06 19 32 | D | | this | | | 4178 | 65 | 106 | NPI | 10212223 |
| 5 | 05 14 02 | 07 21 46 | E | | one | | | 5099 | 88 | 218 | NPI | 4586 19 |
| 6 | 16 15 03 | 08 30 56 | F | | means | | | 9999 | 99 | 999 | NPI | 999999 |

25. FEDERAL TAX I.D. NUMBER: 012-345-6789 SSN EIN:

26. PATIENT'S ACCOUNT NO.: 123456

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

28. TOTAL CHARGE: $ 100000 | 00

29. AMOUNT PAID: $ 00120 | 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: 9/13/12

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): 1EG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Franklin, Ben

3. PATIENT'S BIRTH DATE: 10 | 18 | 60 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1 Milk Street

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

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

CITY: Boston STATE: MA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 02108 TELEPHONE (Include Area Code): ( )

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM | DD | YY 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: Medicare

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: Ben Franklin 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:

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: I.M. Prescribing Provider

17a:

17b. NPI: 0111111110

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: 51902 B: C: D:

E: 5803 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 | 10 07 18 | 10 31 18 | 12 | | E0600 | RR | 12 | 2000 00 | 1 | | NPI | |
| 2 | 10 07 18 | | 12 | | B9002 | | 12 | 1500 00 | 1 | | NPI | |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE: $ 3500 00

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. Provider
1 W Williams ST
Boston, MA 02108

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

PICA

CARRIER

PATIENT AND INSURED INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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) |
| X | | | X | | X | | 6274977 |

| | | | |
|---|---|---|---|
| 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) | |
| Pat Sajak | 10 10 1905 M X F | Alex Trebek | |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS (No., Street) | |
| 123 This st. | Self Spouse X Child Other | 896 Drive Avenue | |
| CITY | STATE | CITY | STATE |
| Chicago | MO | Los Angeles, ~~Missouri~~ | IL |
| ZIP CODE | TELEPHONE (Include Area Code) | ZIP CODE | TELEPHONE (Include Area Code) |
| 12345 | (785) 555-5586 | 63188 | (123) 789 1010 |
| 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 | |
| Vanna White | | 777111222 | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) | a. INSURED'S DATE OF BIRTH MM DD YY / SEX | |
| 679278AB | X YES NO | 10 13 1984 M X F | |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) | |
| | YES X NO | | |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| | YES X NO | Not cool Plan | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC) | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | |
| Cool 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 [signature] DATE 12/12/2012

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 / QUAL | 15. OTHER DATE QUAL / MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | |
| 30 15 1998 QUAL | QUAL 12 25 0000 | FROM 04 10 14 TO 06 10 19 | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | |
| Healthcare.gov | 17b. NPI | FROM 05 20 20 TO 05 10 20 | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? / $ CHARGES | |
| | | X YES NO 100,000 00 | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind | | 22. RESUBMISSION CODE / ORIGINAL REF. NO. | |
| A. B. C. D. | | 84 10 | |
| E. F. G. H. | | 23. PRIOR AUTHORIZATION NUMBER | |
| I. J. K. L. | | 1000 | |

| 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 12 14 15 | 12 34 56 | | | ABC | | | 1000 00 | 1 | | NPI | |
| 2 10 17 20 | 11 38 56 | | | DEF | | | 2500 00 | 2 | | NPI | |
| 3 06 16 01 | 12 99 50 | | | HIJ | | | 1750 00 | 3 | | NPI | |
| 4 02 17 93 | 06 17 94 | | | LMNO | | | 1900 00 | 4 | | NPI | |
| 5 04 15 97 | 05 15 99 | | | PQRS | | | 1 00 | 5 | | NPI | |
| 6 01 33 45 | 12 34 56 | | | TUV | | | | | | NPI | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. Rsvd. for NUCC Use |
|---|---|---|---|---|---|
| 3344556678 X | 1111 | X YES NO | $60,666 00 | $ 0 00 | |

| 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.) | 32. SERVICE FACILITY LOCATION INFORMATION | 33. BILLING PROVIDER INFO & PH # ( ) |
|---|---|---|
| SIGNED DATE | Everywhere, USA | |
| | a. NPI b. | a. NPI b. |

PHYSICIAN OR SUPPLIER INFORMATION