HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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

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

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)
Jonathan Lyman.	12 01 1991 (M) F	Lymon Joe.

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1415 City	Self ☐ Spouse ☐ Child ☑ Other ☐	1514 city place.

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
ST. louis			ST. Charles.	

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
00001	(818) 000-1000	20001	(611) 591-1234

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
Lymon Joe.		
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 2345678	a. EMPLOYMENT? (Current or Previous) ☑ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 12 01 1965 (M) F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☑ YES ☐ NO PLACE (State): MO	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: Omega	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: Sep 31 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: [signature]

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
10 10 2019 QUAL	9 28 2019	FROM 10 10 2019 TO 10 1 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
D. Luke.			FROM 9 10 2019 TO 10 30 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? ☑ YES ☐ NO	$ CHARGES
		450

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

A. fever	B. headach	C. leg pain	D.
E. chills	F. a rasher	G. migraine	H.
I. lethargy	J. Constipation	K.	L.

22. RESUBMISSION CODE	ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 101010

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 19	9 11 19	MO	EMG	OPT			50	4	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.)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
Sumania	0001001	☑ YES ☐ NO	$ 50	$ 50	

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 # ( )
Suha 10 1 19 SIGNED DATE	3 city place. 1st Chicago, St louis. a. b.	America. a. b.

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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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)	wBG587934m287
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)
Bear, Fezzie T	2 15 1987 M[X] F[ ]	Bird, Big Y
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1C Sesame Street	Self [X] Spouse [ ] Child [ ] Other [ ]	123 medical Ave
CITY: St. Louis STATE: MO	8. RESERVED FOR NUCC USE: Total Cost 8	CITY: Kansas City STATE: MO
ZIP CODE: 63139 TELEPHONE (Include Area Code): (538) 976-1561		ZIP CODE: 63005 TELEPHONE (Include Area Code): (512) 348-9635
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
Pichello, Ernie G		m60197w325
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 127K35M26L	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX: 05 15 1985 M[X] F[ ]
b. RESERVED FOR NUCC USE: Out Patient	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): 123874
c. RESERVED FOR NUCC USE: Charges	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem Blue Cross
d. INSURANCE PLAN NAME OR PROGRAM NAME: Stuffed Puppet	10d. CLAIM CODES (Designated by NUCC): CLMCD5	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: Fozzie T. Bear 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: Big Bird

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 1 19 QUAL:	15. OTHER DATE QUAL: 8 MM DD YY: 8 15 19	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 10 1 19 TO 10 1 20
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: OSCAR Grouch	17a: 17b NPI: MON64K	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 6 1 19 TO 9 30 19
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): BOGO LOGO 700		20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 150 80
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE: 5 ORIGINAL REF. NO.: TK98
A: Z0-F3 B: F1-35 C: 38G D: 63J E: 22J F: S1-F G: 67D H: 34F I: K35 J: M61 K: 45K L: M7J		23. PRIOR AUTHORIZATION NUMBER: ZA015J

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 03 02 19	03 02 19	11	Y	CPT 71L19	G		198 64	1		NPI	b954238
2 03 28 19	03 28 19	m	N	HCPCS m35K5			216 86	1		NPI	3824167
3 04 05 19	04 05 19	D	N	CPT D4JL	L-10		345 12	1		NPI	2495
4 04 16 19	04 16 19	L	Y	HCPCS K315	T4		5681 35	1		NPI	1264 88
5 05 30 19	05 30 19	Z	N	HPCSC z m09	0-1		1401 96	1		NPI	8KL745
6 06 18 19	06 18 19	K	Y	TPC A CD	Z 53		68 24	1		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
123487620 [X]	12389560	YES [ ] NO [X]	$ 8234 67	$ 3984 91	

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 # (636) 581-3468
SIGNED: Bert Kenedo DATE:	Crve Coeur Lake	Sesame Street USA
	a. 0 b.	a. SCKTO 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): BR549

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bueller, Ferris F

3. PATIENT'S BIRTH DATE MM DD YY: 1 20 70 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1127 Church St.

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

7. INSURED'S ADDRESS (No., Street): 1127 Church St.

CITY: Shermer STATE: IL

8. RESERVED FOR NUCC USE

CITY: Shermer STATE: IL

ZIP CODE: 60062 TELEPHONE (Include Area Code): 847 867-5309

ZIP CODE: 60062 TELEPHONE (Include Area Code): (847) 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: 42745N 875027W

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

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

a. INSURED'S DATE OF BIRTH MM DD YY: 6 17 48 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield

d. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield

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: Ferris Bueller DATE: 6/11/1986

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: Katie Bueller

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 11 1986 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: 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 11 86	06 11 86			Dr. Appt		F/U	125 00			NPI	ABC123
2 06 11 86	06 11 86			Cindy Grim		Fun	75 00			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: 3211962

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

28. TOTAL CHARGE: $ 200 00

29. AMOUNT PAID: $ 25 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.)

Cameron Frye 6/11/86

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH# ( )

a. 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

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): 65539787

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Tyler, Liv

3. PATIENT'S BIRTH DATE MM DD YY: 09 30 90 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 104678 Vine

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

7. INSURED'S ADDRESS (No., Street): 3218 5th Ave

CITY: Hollywood | STATE: CA

8. RESERVED FOR NUCC USE

CITY: New York | STATE: NY

ZIP CODE: 54378 | TELEPHONE (Include Area Code): (212) 5547444

ZIP CODE: 01234 | TELEPHONE (Include Area Code): (212) 5554444

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 [X]

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

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

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4536426

a. INSURED'S DATE OF BIRTH MM DD YY: 06 06 56 SEX M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: myhealthplan

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 DD YY: 07 01 19 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. K35.3 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 07 01 19	07 23 19									NPI	1295319599
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 $ 123948.54

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

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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#)
X						

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 655394787

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE MM DD YY / SEX M F	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
Tyler, Liv		Tyler, Steven
5 PATIENT'S ADDRESS (No., Street): 104678 Vine	6 PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7 INSURED'S ADDRESS (No., Street): 3218 5th Ave
CITY: Hollywood	STATE	8 RESERVED FOR NUCC USE	CITY: New York	STATE
ZIP CODE: 54376	TELEPHONE (Include Area Code): (212) 5554444		ZIP CODE: 01234	TELEPHONE (Include Area Code): (212) 5554444
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: 45364726
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous) YES NO X	a INSURED'S DATE OF BIRTH MM DD YY: 06 06 56 / 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 NO X	c INSURANCE PLAN NAME OR PROGRAM NAME: my healthplan
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) MM DD YY	15 OTHER DATE QUAL MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
07 01 19 QUAL		
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		22 RESUBMISSION CODE / ORIGINAL REF NO
A K35.3 B C D E F G H I J K L		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 07 01 19 07 23 19									NPI	1245319547
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 $12349854	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.)	32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a NPI b	a NPI 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): 23435023

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 19 70 SEX M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [X] 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

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

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 03 19 70 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: My Homestate Health

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 _____ 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 DD YY: 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

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 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

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 [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): 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): Jones, Mary L

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

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

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

CITY: Springfield STATE: [illegible]

8. RESERVED FOR NUCC USE

CITY: Springfied STATE: [illegible]

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

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

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 [X]

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

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

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1234 5W567

a. INSURED'S DATE OF BIRTH: 03 | 19 | 70 SEX: M [ ] F [X]

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: MY Homestake 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 _____ 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 59	3		NPI	1234 5379399
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

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): 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 [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: 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: MM DD YY 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: MM DD YY FROM 02 28 93 TO 04 06 93

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ 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		100			NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: 549670726

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

28. TOTAL CHARGE: $ 2.10

29. AMOUNT PAID: $ 2.10

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 65594

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (618) 789 4561 88 Good Place, Eleanor, CA 78453

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 [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): 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

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

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	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.

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): 329843023498

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John 1

3. PATIENT'S BIRTH DATE MM DD YY: 1 1 60 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John 1

5. PATIENT'S ADDRESS (No., Street): 1234 Example Street

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

7. INSURED'S ADDRESS (No., Street): 1234 Example Street

CITY: St. Louis | STATE: MO

8. RESERVED FOR NUCC USE

CITY: St Louis | STATE: MO

ZIP CODE: 63141 | TELEPHONE (Include Area Code): (123) 1234567

ZIP CODE: 63141 | TELEPHONE (Include Area Code): (123) 1234567

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: 2343DFSD

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 1 1 60 | 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: Medicare

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: John Doe DATE: 8/21/2019

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 Doe

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 21 2019 QUAL: asdfdsa

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 08 21 2019 TO 08 28 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr Doctor Knows-Stuff

17a:

17b NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 08 21 2019 TO 08 25 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 1700 00

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

A. G31.81 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 08 21 19	08 26 19	HOS	Y	B4034			1700 00	1	N	NPI	1245319399
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 123456798 SSN EIN: [X]

26. PATIENT'S ACCOUNT NO.: 239483929

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

28. TOTAL CHARGE: $ 1700 00

29. AMOUNT PAID: $ 1650 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

1 Hospital Way
St Louis, MO 12345

a NPI b

33. BILLING PROVIDER INFO & PH # (123) 4567898

1 Billing Way
St Louis, MO 12345

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): 329843023498

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

3. PATIENT'S BIRTH DATE: MM 1 DD 1 YY 60 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John I

5. PATIENT'S ADDRESS (No., Street): 1234 Example Street

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

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

CITY: St. Louis STATE: MO

8. RESERVED FOR NUCC USE

CITY: St. Louis STATE: MO

ZIP CODE: 63141 TELEPHONE (Include Area Code): (123)1234567

ZIP CODE: 63141 TELEPHONE (Include Area Code): (123)1234567

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: 2343DFSD

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: MM 1 DD 1 YY 60 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: Medicare

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 John Doe DATE 8/21/2019

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 Doe

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 08 DD 21 YY 2019 QUAL asdfdsa

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 08 21 2019 TO 08 28 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr Doctor Knows-Stuff

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 08 21 2019 TO 08 25 2019

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. G31.81 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 08 21 19	08 25 19	11	Y	B4034			1700 00	1	N	NPI	1245319399
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 123456798 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 239483929

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

28. TOTAL CHARGE: $ 1700 00

29. AMOUNT PAID: $ 1650 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: 1 Hospital Way St. Louis, MO 12345

a NPI b

33. BILLING PROVIDER INFO & PH #: (1234567898 1 Billing Way 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: 05716444 (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FINN, NEMO B	3. PATIENT'S BIRTH DATE: 8 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 [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 42 Wallaby Way	
CITY: Sydney STATE: NL	8. RESERVED FOR NUCC USE
CITY: Sydney STATE: NL	
ZIP CODE: 59876 TELEPHONE (Include Area Code): (431)1234567	ZIP CODE: 59876 TELEPHONE (Include Area Code): (231)2345067
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: RES351414	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH: 5 4 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: Deep Sea 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: Nemo Finn DATE: 5/17/18

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): 2 21 06 QUAL: BAD	15. OTHER DATE QUAL: MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 2 9 08 TO 2 15 10	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Young	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 2 28 12 TO 4 6 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	22. RESUBMISSION CODE: ORIGINAL REF. NO
A B C D E F G H I J K L	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 2 8 00	11	55	99243	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: 885 Ocean Dr. Pacific, OR 43267 a. NPI b.		33. BILLING PROVIDER INFO & PH #: 5874578962 712 Canal Rd Watertown, NK 44573 a. NPI b.		

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