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)

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

3. PATIENT'S BIRTH DATE: 02 22 80 SEX: M [✓] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): WILLIAMSON SARAH B

5. PATIENT'S ADDRESS (No., Street): 76 ALPHA ST

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

7. INSURED'S ADDRESS (No., Street): 97 LAKE DRIVE

CITY: OZARK STATE: MO

8. RESERVED FOR NUCC USE: this is sparta

CITY: LAKE STATE: MO

ZIP CODE: 62405 TELEPHONE (Include Area Code): (721) 2122234

ZIP CODE: 42411 TELEPHONE (Include Area Code): (270) 229-2452

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: AIIIIIALIAIITI

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

a. INSURED'S DATE OF BIRTH: 02 02 80 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE: not reserved

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

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

c. RESERVED FOR NUCC USE: NONE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC): 456 21 52

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: Jae Dent DATE: 09/23/19

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

SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: NO

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM: 02 12 1982 TO: 02 15 80

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN DOE

17a:

17b. NPI: 0294234

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): THIS IS WRITING

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 42 42

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

A. BETA B. STOMA C. D.
E. ZETA F. ALPHA G. H.
I. TETA J. K. L.

22. RESUBMISSION CODE: ABC ORIGINAL REF. NO.: 4214

23. PRIOR AUTHORIZATION NUMBER: 4206 7257

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 24 53		01 10 42		NJ			452	2	A	9999 99	2		NPI	42156
2	8 85 14		02 00 12		MO			C9C4	5 7	B	000 14	1		NPI	67345
3	15 27 6		5 02 56		AL			1568	4	C	20 13	4		NPI	22221
4	99 12 14		4 01 75		MO			2567	A	D	1 34	5		NPI	47842
5	02 15 78		5621 82		IL			1342	B	E	7 17 77	6		NPI	56307
6	02 11 11		44 24 41		NJ			2521	6	F	2000 00	7		NPI	88888

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]: 8X4725982 52

26. PATIENT'S ACCOUNT NO.: 0725000

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

28. TOTAL CHARGE: $ 1745 42

29. AMOUNT PAID: $ 000 00

30. Rsvd for NUCC Use

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

SIGNED: DATE:

32. SERVICE FACILITY LOCATION INFORMATION: Downstairs Basement

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ): Direct Pay Only

a. NPI b.

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

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

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): 879777815

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wozzer, Erik, C

3. PATIENT'S BIRTH DATE: 06 | 12 | 1955 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Wozzer, Sammy, R

5. PATIENT'S ADDRESS (No., Street): 123 Any street Dr.

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

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

CITY: Gotham STATE: AR

8. RESERVED FOR NUCC USE

CITY: Gotham STATE: AR

ZIP CODE: 12345 TELEPHONE (Include Area Code): (604) 175-2649

ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 7256125

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: AR761MNZ34

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 15 | 20 | 1901 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Great Plans

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: [signature] DATE: 12-25-19

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

SIGNED: [signature]

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 12 | 13 | 2019 QUAL:

15. OTHER DATE QUAL: MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM | DD | YY FROM 09 | 27 | 2019 TO 05 | 27 | 2050

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Another Person

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? [X] YES [ ] NO $ CHARGES: 25 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: 12697 ORIGINAL REF. NO.: 4

23. PRIOR AUTHORIZATION NUMBER: 12FB789

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: 842-768-32 SSN [X] 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

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): 241370PB3

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

3. PATIENT'S BIRTH DATE MM 3 DD 9 YY 86 SEX M [✓] F [ ]

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

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

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

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

CITY: St. Louis STATE: MO

8. RESERVED FOR NUCC USE

CITY: St. Louis STATE: MO

ZIP CODE: 63088 TELEPHONE (Include Area Code): (314) 123-0101

ZIP CODE: 63088 TELEPHONE (Include Area Code): (314) 123-0101

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 3 DD 9 YY 86 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: Anthem

10d. CLAIM CODES (Designated by NUCC): 1C3

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: Mario Aguilar DATE: 9/27/2019

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: Mario Aguilar

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 4 DD 3 YY 19 QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 5 1 19 TO 9 10 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Primary Care

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 6 3 19 TO 6 10 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: 43BC 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 6 3 19	6 10 19	CD					14,572 13	7		NPI	432ABCX
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 123-45-6789 SSN [✓] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 99937654

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

28. TOTAL CHARGE: $ 14,572 13

29. AMOUNT PAID: $ 0 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: 9/10/19

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1EG4-TE5-MK72

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

3. PATIENT'S BIRTH DATE: 10 30 1935 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 141 Franklin St

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

7. INSURED'S ADDRESS (No., Street): 141 Franklin St

CITY: Quincy STATE: MA

8. RESERVED FOR NUCC USE

CITY: Quincy STATE: MA

ZIP CODE: 02169 TELEPHONE (Include Area Code): (617) 770-1175

ZIP CODE: 02169 TELEPHONE (Include Area Code): (617) 770-1175

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 10 30 1935 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare

d. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: John Adams DATE: 9-27-2019

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 Adams

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 9 1 2019 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. 90210 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 9 1 19	9 4 19	11		G3410		1	345 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 344-72-8950 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.:

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

28. TOTAL CHARGE: $ 345 00

29. AMOUNT PAID: $ 50 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: Massachusetts General Hospital, 55 Fruit St, Boston, MA 02114

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

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	23411

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)
Alex Friday	01 01 2001 M [ ] F [X]	Alex Friday

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1 Road	Self [X] Spouse [ ] Child [ ] Other [ ]	1 Road

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Cox Town	FL		Cox Town	FL

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
6000	(414) 515 6161	6000	(414) 515 6161

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 01 01 2001 M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED [signature] DATE Sep 26 2009

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 FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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								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.)	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

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): 12345 DBA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Masko, Duke W

3. PATIENT'S BIRTH DATE: 09 | 43 | [illegible] SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Monster Mar W

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

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

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

CITY: St. Louis | STATE: MO

8. RESERVED FOR NUCC USE

CITY: " | STATE: "

ZIP CODE: 63117 | TELEPHONE (Include Area Code): (351) 155-7212

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1543212

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

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

a. INSURED'S DATE OF BIRTH: 08 | 15 | 01 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE: Hey Hey

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

b. OTHER CLAIM ID (Designated by NUCC): 151121215

c. RESERVED FOR NUCC USE: Yo Yo

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross

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

10d. CLAIM CODES (Designated by NUCC): 577954

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: [signature]

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

SIGNED: [signature]

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01 | 12 | 2012 QUAL:

15. OTHER DATE: QUAL: MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM | DD | YY FROM 09 | 15 | 2010 TO 12 | 30 | 17

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

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM | DD | YY FROM 04 | 10 | 2012 TO 10 | 12 | 2014

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Nursing

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 43000

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

A. Sick | B. Concussion | C. Sinus | D.
E. Fever | F. Flu | G. Heart | H.
I. Illness | J. Cold | K. Diabetes | L.

22. RESUBMISSION CODE: 52110 ORIGINAL REF. NO: 520011

23. PRIOR AUTHORIZATION NUMBER: 5100210

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 19	09 19	09	X							NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 555-555-555 SSN EIN: 555

26. PATIENT'S ACCOUNT NO.: 1111111

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

28. TOTAL CHARGE: $ 5000 15

29. AMOUNT PAID: $ 25,000 15

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:

32. SERVICE FACILITY LOCATION INFORMATION: SLCC

a. NPI: b.

33. BILLING PROVIDER INFO & PH #: ( ) BCBS 555-111-2222

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): BD58096421

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Roberts, Hermione, G

3. PATIENT'S BIRTH DATE: 06 | 31 | 82 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Weasley, Ron, J

5. PATIENT'S ADDRESS (No., Street): 457 Burrow St.

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

7. INSURED'S ADDRESS (No., Street): 457 Burrow St.

CITY: London STATE: NY

8. RESERVED FOR NUCC USE

CITY: London STATE: NY

ZIP CODE: 63011 TELEPHONE (Include Area Code): (314) 123-8764

ZIP CODE: 6804 TELEPHONE (Include Area Code): (314) 987-4231

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: W4984016

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 08 | 17 | 80 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

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: Anthem

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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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: Ron Weasley

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 08 | 31 | 2019 QUAL:

15. OTHER DATE QUAL: MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM | DD | YY FROM 08 | 31 | 2019 TO 09 | 31 | 2019

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM | DD | YY FROM 08 | 31 | 2019 TO 09 | 02 | 2019

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. X 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 31 19	09 02 19	Mercy				Wand	3		NPI	12487612
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 8146794 SSN EIN: 312

26. PATIENT'S ACCOUNT NO.: 12468109

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

28. TOTAL CHARGE: $ 10000

29. AMOUNT PAID: $ 800

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

Adam Lenau

HEALTH INSURANCE CLAIM FORM

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

PICA

1 MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a INSURED'S I.D. NUMBER (For Program in Item 1)
[X] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [ ] (ID#)	153724925
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Robert, Smith, L	3 PATIENT'S BIRTH DATE MM DD YY 09 31 86 SEX M [X] F [ ]
4 INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted] Jones, Blake, R	
5 PATIENT'S ADDRESS (No., Street) 47 Rue De Grand	6 PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]
7 INSURED'S ADDRESS (No., Street)	
CITY 63367	STATE MO
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )
8 RESERVED FOR NUCC USE	
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) [X] YES [ ] NO
a INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? [X] YES [ ] NO PLACE (State)
b OTHER CLAIM ID (Designated by NUCC)	
c RESERVED FOR NUCC USE	c OTHER ACCIDENT? [ ] YES [X] NO
c INSURANCE PLAN NAME OR PROGRAM NAME	
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)
d IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED [signature] 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 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		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								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

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

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

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

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): 8675309

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hamilton, Lewis

3. PATIENT'S BIRTH DATE: MM 01 DD 07 YY 85 SEX M [X] F [ ]

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

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

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

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

CITY: Washington STATE: D.C.

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 20500 TELEPHONE (Include Area Code): (136)-357-6666

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

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: Red

d. INSURANCE PLAN NAME OR PROGRAM NAME: Real Good Insurance Plan

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [X] 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:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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: Lewis Hamilton DATE: 9/27/18

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:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 09 DD 27 YY 18 QUAL:

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a:

17b. NPI:

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

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

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

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

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

26. PATIENT'S ACCOUNT NO.:

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

28. TOTAL CHARGE $:

29. AMOUNT PAID $:

30. Rsvd for NUCC Use:

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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): 000010

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Martha X Dan

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 2001 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Martha X Dan

5. PATIENT'S ADDRESS (No., Street): 1 city place, St louis 63021

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

7. INSURED'S ADDRESS (No., Street): 1 city place, St. louis 63021

CITY: St. louis STATE:

8. RESERVED FOR NUCC USE

CITY: St. louis STATE:

ZIP CODE: 63021 TELEPHONE (Include Area Code): (800) 800-8000

ZIP CODE: 63021 TELEPHONE (Include Area Code): (800) 800-8000

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 62A7

a. OTHER INSURED'S POLICY OR GROUP NUMBER: X12141

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED [signature] DATE Sep 2 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 09 DD 11 YY 2018 QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A B C D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b

33. BILLING PROVIDER INFO & PH # ( )

a NPI b

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Radish, Josie, K

3. PATIENT'S BIRTH DATE: MM 9 DD 17 YY 1989 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1117 Cleveland Ave

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

7. INSURED'S ADDRESS (No., Street): 1100 Michigan Ave

CITY: Kirkwood | STATE: Mo

8. RESERVED FOR NUCC USE

CITY: Purchase | STATE: NY

ZIP CODE: 63122 | TELEPHONE (Include Area Code): (314) 800-8766

ZIP CODE: 31021 | TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: GM01761A

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

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

b. RESERVED FOR NUCC USE

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

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: Sunshine 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: Josie Radish DATE: 9/18/19

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A B C D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 3 4 19	4 5 19			A5K			750 99			NPI	1740985321
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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.