

PICA									-	PICA TT
MEDICARE MEDICALD  (Medicares) (Medicalds)		CHAMPVA	GROUP HEALTH F	FECA BLKLUN (ID#)	OTHER	1a. INSURED'S I.D BR549	NUMBER	•	(For Fragram	in Item t)
2. PATIENT'S NAME (Last Name,		٦.	PATIENTS BIR		SEX	4. INSURED'S NAM	fE (Last Name,	First Name, f	Middle Initial)	
Hunt, Ethan, S			09 11	1990 м×	¹ F	Hunt, Etha				
5 PATIENT'S ADDRESS (No., S) 117 St. Clair St.	reet)	(		ATIONSHIP TO INS		7. INSURED'S ADD		eet)		
CITY		STATE	Self X Spou		Other	CITY	all Ot.		1	STATE
Glendale		TX	i)	1989		Glendale				TX
ZIP CODE	TELEPHONE (Include Area					ZIP CODE			(Include Area (	
76158 9. OTHER INSURED'S NAME (La	(314) 867-5309			CONDITION RELA	TED TO	76158	1004 600 010	,	) 867-53	09
n/a	Strane, mor mane, music	**************************************	10. IS FATILITY 5	COMMINGNATION	10.	FY832IG0		JA FECA NO.	MBEH	
a. OTHER INSURED'S POLICY C	OR GROUP NUMBER		a. EMPLOYMENT	? (Current or Previo	ous)	a INSURED'S DAT	E OF BIRTH		SEX	
n/a b. RESERVED FOR NUCC USE			b. AUTO ACCIDE	YÉS NO		09   1 <sup>-</sup>	1   1990	М	×	F
				YES NO	PLACE (State)	b. OTHER CLAIM!	D (Designated	by NUCC)		
c. RESERVED FOR NUCC USE			c. OTHER ACCID	ENT?	<u> </u>	C. INSURANCE PLA	N NAME OF F	PROGRAM N	AME	
			X			Insurance				
d INSURANCE PLAN NAME OR	PHOGRAM NAME	1	IOd. CLAIM CODE	ES (Designated by I	NUCC)	d ISTHERE ANOT			MN? e items 9, 9a, ar	nd Od
READ	BACK OF FORM BEFORE C	OMPLETING (	A SIGNING THIS	FORM.		13 INSURED'S OR	AUTHORIZED	PERSON'S	SIGNATURE I a	uthorize
<ol> <li>PATIENT'S OR AUTHORIZED to process this claim. I also requestion</li> </ol>						payment of med services describ		the undersign	ed physician or	supplier for
SIGNED										
14. DATE OF CURRENT ILLNES:	S, INJURY, or PREGNANCY	(LMP) 15. (T	DATE_ THER DATE			16. DATES PATIEN	T UNABLE TO	WORK IN CL	JERENT COCU	PATION
	JAL	QUAL	-	MM DD	YY		11 2019			2019
17. NAME OF REFERRING PRO	VIDER OR OTHER SOURCE	17a				18 HOSPITALIZATI	ON DATES RE	LATED TO C	WARENT SER	VICES YY
Dr. Brian Smith	MTION (Designated by NUCC	17h	NPI			FROM 09	11 2019		09 13	2019
						XYES	NO		9999.00	
21. DIAGNOSIS OR NATURE OF		_		ICD Ind		22. RESUBMISSION	N .	CRIGINAL RE	=====±====== F. NO.	
Head Tram	Broken Fee	c <u>B</u>	roken F	D		OU812 29. PRICE AUTHO		/TF73		
E [Diokeil OB	F DIOKEII OD	G L		н Ц		BS123	HIZA (I CAT ITO)	- CEN		
24. A DATE(S) OF SERVICE From T	E B. C		URES, SERVICES Unusural Circums		E. DIAGNOSIS	Æ	G.	H. I.		J. DERING
MM DD YY MM D		OPT/HCPC:		MODIFIER	PONTER	S CHARGES	DAYS E OR UNITS	PSDT ID sinity Plan OUAL		DER ID. #
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								NPI		
25 FEDERAL TAX I D NUMBER	SSN EIN 26 I	PATIENT'S AC	COUNT NO	27 ACCEPT AS	¬	28 TOTAL CHARG	150	MOUNT PAI	D 30 Asv	d for NUCC Use
31 SIGNATURE OF PHYSICIAN	OR SUPPLIER 32 9	SERVICE FAC	ILITY LOCATION	INFORMATION	ИО	33 BILLING PROM	DER INFO & P	H# (		
INCLUDING DEGREES OR C (I certify that the statements or	REDENTIALS The reserve			W 100 - 1				1	,	
apply to this bit and are made	a part hereof.)									
	9/26/19	N/O	b.			a NP	b.			
SIGNED	DATE	1141				To DU		-		



1 MEDICARE MED	CAID TRIC	CARE	CHAMPVA	00015		TCA	OTHER	1a INSURED'S I D. NU	N IDED			PICA
(Medicare#) X (Medicare#)		(DoD#)	(Member IDA	HEALTI	H PLAN B	ECA LKLUNG D#)	(ID)	316kh87	MBEH		(For Progra	m in Hem 1)
2 PATIENT'S NAME (Last I Mars, Veronica R	Name, First Name,	Middle Initial)		PATIENT'S I	)   YY	SEX	- - L	4 INSURED'S NAME ( Mars, Keith L	Last Name, I	First Name,	Middle Initial)	
PATIENT'S ADDRESS (N 4482 Jefferson St /			6		ELATICNSHIP T			7 INSURED'S ADDRE 4482 Jefferson	, ,	,	100000	
CITY	1pt 20		STATE 6	Self X S	pouse Child FOR NUCC US		3	CITY	Ot Apt 20			STATE
Neptune			CA					Neptune				CA
ZIPCODE	1.	JE (Include Area	Code)					ZIP CODE	1		E (Include Are	
87155 OTHER INSURED'S NAM	,	5483257	In(tral) 1	D IS PATIENT	I'S CONDITION	I REI ATEN 1	10	87155	Y GROUP C		)872487	2
								jrtr872	· dilesi e	or con no	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
OTHER INSURED S POL	ICY OR GROUP N	NUMBER	8	EMPLOYME	PAT? (Current or	Previous)		a INSURED SDATE C	OF BIRTH		SEX	
AESERVED FOR NUCC	USE			L D. AUTO ACCI	YES	NO		10   31	69		×	F
					YES	NO I	(State)	b. OTHER CLAIMID (I	nesignated c	by NUCC)		
RESERVED FOR NUCC	USE			OTHER ACC	DENT?			C INSURANCE PLAN	NAME OR P	ROGRAMIN	IAME	
					YES	NO		Neptune Health				
INSURANCE PLAN NAM	E OR PHOGRAM (	NAME	1	OR CLAIM CO	IDES (Designat	ed by NUCC	)	d IS THERE ANOTHER			AN? Ie items 9, 9a,	and Od
RATIFICATION OF A LITTLE	EAD BACK OF FO	ORM BEFORE C	OMPLETING (	HE DAINOIS	IS FORM.		-	13 INSURED'S OR AU	THORIZED	PERSON'S	SIGNATURE	l authorize
2 PATIENT'S CR AUTHO to process this claim I als below	so request payment	of government b	enefits either to	myself or to the	e party who acce	formation nec epts assignme	essary mi	payment of medical services described t	benefits to ti below	he undersigr	ned physician	or supplier for
SIGNED Veronica N	flars			DATE	8/12/03			SIGNED Keith I	Mars			
O7 12 2013	CUAL fine		QUAL	HER DATE	мм   D	D YY		16 DATES PATIENT U MM DD FROM 05 11	NABLE TO		URRENT 000 MM 000 02 08	2020
7 NAME OF REFERRING  Will Grace	PROVIDER CR O	THER SOURCE		100				18 HOSPITALIZATION	YY .		MM DD	T YY
9 ADDITIONAL CLAIM IN	FORMATION (Desi	gnated by NUC	17h	DIPI				FROM 06 13 20 OUTSIDE LAB?	2008		03 22 HARGES	2012
								X YES	NO		1000,01	
1 DIAGNOSIS OR NATUR	RE OF ILLNESS OF	RINURY Relat	e A-L to service	line below (24	E) ICD Ind			22 RESUBMISSION CODE		RIGINAL RI	EF NO.	
E00-E90	В		د ا		- D	ļ		23 PRICE AUTHORIZ	ATION NUM	BER		
	F L		G L		H.							
4 A DATE(S) CF SE	ANCE	B. C. PLACE OF		URES, SERVIO Unusual Circu	CES, OR SUPPL		E. GNOSIS	F	G DAYS	H. 1	951	J NDERING
AM DD YY MAV		SERVICE EMG	CPT/HCPC		MODIFIER		INTER	S CHARGES	OR R	amily ID Plan QUAL		ADER ID.
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5 FEDERAL TAX I D NUT	WBER SSN		PATIENT'S AC	COUNT NO		PT ASSIGN	MENT?	28 TOTAL CHARGE		MOUNT PA		svd for NUCC Us
326879832 B1. SIGNATURE OF PHYSI	CLAN CO GLIDO IA		6ku8	HEN LOOSE	X YES				.94 \$	1 a I ==	0	
INCLUDING DEGREES (I cer lify that the statement apply to this bit and are	CR CREDENTIAL: ents on The reverse	S 843 of) Spri	57 Stacy Rd ingfield, OR	GIT LOCATIO	ON INFORMATI	IUN		33 BILLING PROVIDE Candy Cane Loop North Pole, LA	h info&Pf	H# (654	) 55798	lb
		798	45	I.				67662				
SIGNED	DATE	а	NE	b.				a. NP1	b.			



PICA			1000						PICA TT
MEDICARE MEDICAID     (Medicald)     (Medicald)		CHAMPV/	HEAL	TH PLAN EECA	NG	1a INSURED'S I D NUME O576444	ŒR .	(For Pro	gram in Item ()
2. PATIENT'S NAME (Last Name	II			BIRTH DATE	SEX	4 INSURED'S NAME (Las	t Name, Fust Nan	ne. Middle Init	al)
Finn, Nemo B			08 1	6 03 M×	F	Finn, Merlin s			_,
5 PATIENT'S ADDRESS (No., St 42 Wallaby Way	reet)			RELATIONSHIP TO IN		7 INSURED'S ADDRESS 42 Wallaby Wa			
CITY		STATE		Spouse Child X	Other	CITY	ıy		STATE
Sydney		AL	71202172	D 1 01111000 00L		Sydney			AL
ZIP CODE	TELEPHONE (Indude	Area Code)				ZIP CODE	TELEPHO	ChiE (Include	Area Code)
59876	(231) 1234	The second secon				59876		31 ) 123	4567
9 OTHER INSURED'S NAME (La	ast Name, First Name, I	Aiddle frital)	10 IS PATIE	IT'S CONDITION REL	ATED TO:	RE351414	ROUP OR FECA	NUMBER	
a OTHER INSURED'S POLICY O	OR GROUP NUMBER		a EMPLOYN	ENT? (Current or Prev	ious)	a INSURED'S DATE OF E	<b>ЗЯТН</b>	S	ĒΧ
v x				YES N	0	05 04	88	м	F
b. RESERVED FOR NUCC USE			b. AUTO ACC		PLACE (State)	b. OTHER CLAIM ID (Des	ignated by NUCC	)	
c. RESERVED FOR NUCCUSE			c OTHER AC	TABENTS N	° L	c. INSURANCE PLAN NAM	IS CO PROCE M	d breken	
			[	YES N	0	Deep Sea Hea		er er er er er er er er	
d INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM C	COES (Designated by	NUCC)	d IS THERE ANOTHER H		PLAN?	
						YES X NO		plete items 9,	
12 PATIENT'S OR AUTHORIZED to process his daim I also req	BACK OF FORM BEF( ) PERSON'S SIGNATU	RE Tauthorize their	elease of any m	nectical or other Informat	ton necessary	13 INSURED'S OR AUTH- payment of medical ber	efits to the under		
telow	uest ptyrientur governi	rem tenens einer i			ssignment	services described belo			
SIGNED Nemo Finn			DAT	E_05/17/18		SIGNED Merlin	Finn		
14 DATE OF CURRENT ILLUIES OZ 21 06 C	S, INJURY, or PREGNA	NCY (LMP) 15 (	THER DATE	MM   DD	YY	16 DATES PATIENT UNA			
17 NAME OF REFERRING PRO						FROM 02 09  18 HOSPITALIZATION DA			15 10
Dre Young			NPI			FROM 02 28			06 14
19 ADDITIONAL CLAIM INFORM	IATION (Designaled by	NUCC)				20 CUTSIDE LAB?		CHARGES	
21 DIAGNOSIS CRINATURE OF	III NESS CO IN III OV	Doloto 8 L to cour	en line botom E	AF.	_	YES X NO		0.0	0
. I		- I	Je lilie Dalow Q	ICO Ind		22 RESUBMISSION CODE	CRIGINAL	REF NO	
E	8. L	_ CL_ _ GL		— О <u>—</u> н I		23 PRICE AUTHORIZATI	ON NUMBER		
1. [	J	ĸ L					121-017-04		
	o PLACE OF	(Emplai	n Unusual Ord	ICES, CR SUPPLIES umstances)	E. DIAGNOSIS		G H I		J RENDERING
MM DD YY MM D	D YY SERVICE	EMG CPT/HCP	S	MODIFIER	PONTER	5 CHARGES U	OR Remark DUA NITS Plan CUA		ROMDER ID. #
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25 FEDERALTAX I D NUMEER		26 PATIENTS A	CCOUNT NO.	27 ACCEPT A	SSIGNMENT?	28 TOTAL CHARGE	29 AMOUNT	PAID 30	) Risyd for NUCC Use
487-89-4578	X _	357634		X YES	МО	s 2152,68		0,00	
31 SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C	REDENTIALS	32 SERVICE FA	CILITY LOCAT	TON INFORMATION		33 BILLING PROVIDER IN 712 Coral Rd	NFO& PH# (	587 ) 45	78962
(I certify that the statements or apply to this bill and are made		Pacific, OR 432	:67			Waterfall, AK 44573			



PICA												PICA T
t. MEDICARE MEDICAL  (Medicales) (Medicalds		CHAMPV: (Member II	- HE	OUP ALTH PLAN	BEKLUNG	OTHER	1a.INSURED'S I 316354Y32		1	(Fo	r Program Ir	item 1)
2 PATIENT'S NAME (Last Name Holms, Phillip, T			<u> </u>	S BIRTH DATE	1	EX F	4. INSURED'S NA Holms, Phil	AME (Last N	ame, First N	lame, Middle	e hilial)	
PATIENT'S ADDRESS (No., S	treet)			RELATIONSH		<u> </u>	7. INSURED'S AD		, Street)		<u> </u>	
888 Strawberry Lane		•				Other	888 Strawb	erry Lane	9			
Paris		MO	8 RESERV	ED FOR NUCC	USE		CITY Paris				9	MO
ZIP CODE	TELEPHONE (Indude	Area Code)					ZIP CODE		TELEF	HONE (Ind	ude Area O	ode)
65812	( 680 ) 800543			a de la companya de l			65812		(	680 )8		
, OTHER INSURED'S NAME (L	ast Name, Hirst Name, IV	rkodię inital)	18. IS PAU	ENT'S CONDIT	ION HELAT	ED 10:	11. INSURED'S F <b>G657</b>	OLICY GHC	JUP OH FE	CA NUMBEI	7	
OTHER INSURED'S POLICY	OR GROUP NUMBER		a. EMPLOY	MENT? (Currer		s)	a. INSURED'S DA			11/54	SEX	- 1
RESERVED FOR NUCC USE			b AUTO A	CODENT?	∐ ио	ACE (State)	b. OTHER CLAIM			M X		
				YES	□ NO	LLL		,c (being	accept to			
RESERVED FOR NUCCUSE			c OTHER	ACCIDENT?			c. INSURANCE P	LAN NAME	OR PROGE	IAM NAME		
I. INSURANCE PLAN NAME OF	LPROGRAM NAME		10d, CLAIM	YES CODES (Desig	materi by til	ICC	Blue Cross	THER HEA	TH DENE	IT DI ANO		
			Tod. GETAIN	, occident	yracca by W	, ,	-  YES	X NO			ns 9, 9a, ano	d 9d.
READ 2. PATIENT'S OR AUTHORIZE to process this claim. I also rec		RE I authorize the i	elease of any	medical or other			13. INSURED'S C payment of me services descr	edical benefit				
SIGNED Phil Holms			D	7/28/09	l		SIGNED PI	nil Holms				
4. DATE OF CURRENT ILLNES	SS, INJURY, OF PREGNA WAL <b>. bad</b>	INCY (LMP) 15. QU.	OTHER DAT			ΥΥ	16 DATES PATIE MM FRCM 05	NT UNABLE	ETO WOR⊩ 000	IN CURRE MM TO 05	OS 08	ATION 2000
7. NAME OF REFERRING PRO	MIDER OR OTHER SOL						19. HOSPITALIZA MM	ם מם	YY	NW	, DD	YY
Tiffany Jones  9. ADDITIONAL CLAIM INFORI	MATION (Designated by		NPI				FROM <b>04</b> 20. OUTSIDE LAI		000	TO 04		2000
							YES	X NO			0.00	
1. DIAGNOSIS OR NATURE O	FILLNESS CR INJURY	Relate A-L to serv	ce line below	(24E) ICD	Ind.		22. RESUBMISSI CODE	ON	CRIGIT	IAL REF. N	a	
A (E00-E90	в	_ C L			D. L		29. PRIOR AUTH	CRIZATION	NUMBER			
E. L	F. L	L GL			H. L E. L.							
	TO PLACEOF		in Unusual C	RVICES, OR SU Froimstances) MODIFIEI		E DIAGNOSIS POINTER	F. \$ CHARGES	G. DAY: OR UNIT:	H. S EPSOT Family S Plan (	I. ID. DUAL	J RENDE PROVID	AING
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		V, TOIL						27				
										NPI		
		-1	1	1 1	1			-	1	NICH .		
S FEDERAL TAX I D NUMBER	NE NEZ	26 PATIENT'S A	ICCOUNT N	27 AC	CEPT ASS 1 DOVE CLAIMS, YES	IGNMENT?	28 TOTAL CHAP	82.78	29 AMOU!	NPI NT PAID D.00		for NUCC Us
31 SIGNATURE OF PHYSICIAN		32 SERVICE FA	CILITY LCC	1 1 1			33 BILLING PRO			(653 )	3543248	
INCLUDING DEGREES OR (I certify that the statements of	on the reverse	53547 Lurry La	ine				Doo Bop Circle			, ,		
apply to this bill and are made	: a part mereor)	Chicago, IL 84873					Boston, PA 42588					
CHANED		a	2 1	b.			4. (1)	21	b.			
SIGNED	DATE	100					1.71		-			



PICA													PICA TT
	MEDICAID	TRICARE		CHAMPVA	GBC HEA	UP LTH PLAN	EK LUN	<u> </u>	1a. INSUREDIS I D. NI	UMBER		(For Pr	ragram in Item 1)
(Medicare#) X (A		(ID#/DcD#)		(Member ID4			(ID#)	(ID#)	TA48769		-		
Rapper, Chan		ane, wadde r -	iigar)	,	05	S BIRTH DATE DD 1 88	мХ	EX F	Rapper, Cha			, Middle In	Ital)
5 PATIENT'S ADDRESS				(		RELATIONSH			7. INSURED'S ADDRE				
100 Michigan	Ave				Self	Spouse (	Child	Other	100 Michiga	n Ave			
CITY				1	RESERV	D FOR NUCC	USE		СПУ	*			STATE
Chicago				IL					Chicago				IL.
45686		PHCNE (Induc		Code)					ZIP CODE				Area Code)
9. OTHER INSURED'S I	( -	9 ) 8572 e. Eirst Name		hital) 1	IN IS PATIF	PITS CONDITI	ON BELAT	ED TO	45686	v apain		9)857	2305
,	(	-, , , , , , , , , , , , , , , , , , ,		,					G88725	i dileoi	CITI ECATI	ONIDETT	
a. OTHER INSURED'S F	POLICY OR GRO	UP NUMBER			EMPLOYI	MENT? (Curren	it or Previo	ıs)	a. INSURED'S DATE O	OF BIRTH			SEX
						YES	NO		05 04	88	K	X	F
b. RESERVED FOR NU	CC USE				B AUTO AC			LACE (State)	b. OTHER CLAIM ID (	Designated	by NUCC)		
c. RESERVED FOR NUC	COLICE				COTHER A	YES	МО						
a neserves run nu	UU VAE			,	OTHEH A	YES	□ NO		Chicagoian	NAME ÇR	HROGRAM	NAME	
I. INSURANCE PLAN N	AME OR PROGR	AM NAME		1	Od CLAIM	CCDES (Desig		UCCI	d. IS THERE ANOTHE	FI HEALTH	BENEFIT P	LAN?	
						,,	,	,	YES X				), 9a, and 9d.
12. PATIENT'S OR AUTI	READ BACK O	F FORM BEF	ORE CO	OMPLETING (	SIGNING	THIS FORM.	r inference	nacenace	13. INSURED'S OR AL	THORIZE	D PERSON'S	SIGNATI	URE I authorize
to process this claim below	l also request pay	ment of govern	nment be	andits other to	myself or to	the party who a	ccepts assi	gnment	payment of medical services described	benefits to below	the undersi	gned physi	cian or supplier for
Chance	e The Rap	ner				11/18/	05		Char	nce Th	e Rappe	ar	
SIGNED CHARLET	-		18NOV /	IMP 46 CO	DA	15			SIGNED				
08 03 92	· .	bad	anaci (	QUAL		ММ	DD	YY	16 DATES PATIENT L			O2	15 93
7. NAME OF REFERRI			DURCE	17a			-		18. HOSPITALIZATION	DATES R		CURREN	T SERVICES
Dre Young	9			17b	NPI				FROM 02 28		т.	04	06 93
19 ADDITIONAL CLAIM	INFORMATION	(Designated b	y NUCC	)					20 CUTSIDE LAB?		\$ (	CHARGES	
									YES X	NO		0.	00
21. DIAGNOSIS OR NAT	FURE OF ILL,NES	SS OFFINATURY	Y Relate	A-Litoiservice	fine below	(24E) ICDI	Ind		22 RESUBMISSION CODE		CRIGINAL F	PEF. NO	
A L	B. L.		_	ا ٥		_			23 PRIOR AUTHORIZ	ATION NU	MBEB		
E L	F. L.			G L		_	H		20 7710710710	ATIGUTE	- COLIT		
24. A DATE(S) CF		8	C.			VICES, CR SUI	PPLIES	E.	F.	G. DAYS	H. I.		d.
From MM DD YY	To MM DD Y	PLACE OF Y SERVICE	EMG	(Explain CPT/HCPCS		oumstances) MODIFIEF	1	DIAGNOSIS POINTER	\$ CHARGES	OR UNITS	Femily ID. Plan QUAL		RENDERING PROVIDER ID. #
						The state of	the larger sand	,	100	*******			Supposed the con-
12 5 99	02 08 0	00 11	55	99213	21				1,00		NPI		
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	-1040-7007						1			2	NPI		
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	711 9	CONTRACTO CO			E-0/20-A/4	No.					and desired		
											NPI		
		TR, T						,					
											NPI		
1 1 1						1 1	1	1	1		_		
25 FEDERALTAXID N	NUMBER	SSN EIN	26 F	PATIENT'S AC	COUNT NO	27 AC	CEPT, ASS	GNMENT?	28 TOTAL CHARGE	20	AMOUNT P	AID Is	30 Rsvd for NUCC U
		×		967026		X Y		see ta(a)	10000	01 \$		2.01	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
458-78-8877			_		HTYLODA	TICN INFORM			33 BILLING PROVIDE		11/1/2		894561
458-78-8877 31 SIGNATURE OF PH			32 5	SERVICE FAC	ar recon	richting Cities			33 BILLING PHOVIDE	31 11 41 4 14 1	The LO	10 1 /	034301
31 SIGNATURE OF PHI INCLUDING DEGRE (I certify that the state	ES CA CREDEN ements on the rev	TIALS Mrse	15 8	Th Ave			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		88 Good Place	31 1141 (12)	(0	10 ) //	034301
31 SIGNATURE OF PH'	ES CA CREDEN ements on the rev	TIALS Mrse	15 8				.,,,,,,,,,			371111 (32)	(0	10 ) //	034301
31 SIGNATURE OF PHI INCLUDING DEGRE (I certify that the state	ES CA CREDEN ements on the rev	TIALS Mrse	15 8	Th Ave					88 Good Place	Ь	(6	10) //	034301



TIPICA			PICA TT
	HEALTH PLAN BLK LUNG		gram in (tern 1)
(Medicare#) (Medicald#) (ID#/DoO#) (Men PATIENT'S NAME (Last Name, First Name, Middle Initial)	beriDa) (IDa) (IDa)	23435O23	
lone, Mary L	O3 19 70 M FX	INSURED'S NAME (Last Name, First Name, Middle Init:     Jone, Mary L	<b>1</b> )
PATIENT'S ADDRESS (No., Steel)	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No , Steet)	
2713 Steety Dr	Self Spouse Child Other	42713 Steety Dr	
Springfield N	IA 8. RESERVED FOR NUCC USE	Springfield	STATE MA
TELEPHONE (Indude Area Code) (213 ) 555-1145		72IP CODE TELEPHONE (Include A 65432 (213 ) 5551	
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	140
		123454567	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Ourrent or Previous)	a. INSURED'S DATE OF BIRTH SE	
RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	b. OTHER CLAIM ID (Designaled by NUCC)	FX
	PLACE (State)	U. OTHER CEANING (Designated by NOCC)	
ESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	
SURANCE PLAN NAME OF PROGRAM NAME	YES X NO	MyHomestate Health	
TOURNOUS FUND HAVE ON FROSHAMINAME	19d: CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES X NO #yes, complete literus 9, 9	Fai, and 9d
READ BACK OF FORM BEFORE COMPLE PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Tauthorize	THE A SIGNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATUR	E I authorize
process this claim. I also request payment of government benefits a delow	ther to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physicial services described below.	an or supplier for
BIGNED	DATE	GOVED	
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15 OTHER DATE	SIGNED  16. DATES PATIENT UNABLE TO WORK IN CURRENT C	CCUPATION
01 02 19 CUAL	QUAL MM DD YY	FROM TO	
NAME OF REFERRING PROVIDER OF OTHER SOURCE	17a		SERVICES D YY
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17b NPI	FROM TO  20 OUTSIDE LAB? \$CHARGES	
		YES NO	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to	service line below (24E) ICD Ind.	22 RESUBMISSION CRIGINAL REF. NO.	,
- <del></del>	0	23. PRIOR AUTHORIZATION NUMBER	
F. L	9 L	23. I TRICK NOT HORIZA NOR HORIZA	
	OCEDURES, SERVICES, OR SUPPLIES Explain Unusual Circumstances) DIAGNOSIS	F. G H. I	J.
	HCPCS   MODIFIER POINTER		ENDERING OVIDER ID. #
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		710,00	
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		NPI NPI	
		NPI NPI	
FEDERALTAXID NUMBER SSN BIN 26 PATIEN	T'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?		Riskd for NUCC U
SIGNATURE OF PHYSICIAN OR SUPPLIER 22 SERVICE	YES NO	\$ \$	
INCLUDING DEGREES OR CREDENTIALS (Locally that the statements on the rewise	E FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH# ( )	
a pdy to this bill and are made a part hereof)			
		parties and the same of the sa	1.9
NED DATE	b.	a b.	



PICA	PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN (Medicaid#) (ID#/DoD#) (Member ID#) (ID#)	PDFQ8765U32 (For Program in term 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initia)  SOLERA CHRISTIE R. 01 02 03 M FX	4. INSURED'S NAME (Last Name, First Name, Middle Initial) FARGINI, LUCA
5. PATIENT'S ADDRESS (NO! Steel)  6. PATIENT'S ADDRESS (NO! Steel)  6. PATIENT RELATIONSHIP TO INSURED  Sell Spouse Child Collect	7. INSURED'S ADDRESS (No., Steet) 323 ZUCCLILII Rd.
Rackvale STATE 8 RESERVED FOR NUCCUSE	
21P CODE TELEPHONE (Indude Area Code) 81226 (211)221-3743	05766 (620315-2719 6
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	ZIP CODE  ZIP CODE  OS 766  (620315-2719  11. INSURED'S POLICY GROUP OR FECA NUMBER  G (7221  a. INSURED'S DATE OF BIRTH  OB 12165  b. OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OR PROGRAM NAME  AETNA PLATINUM PPO  ID IS THERE ANOTHER HEALTH BENEFIT PLAN?
a. OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  TYES INO	a INSURED'S DATE OF BIRTH SEX
b RESERVED FOR NUCCUSE  COD-21720  b. AUTO ACCIDENT?  PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
C RESERVED FOR NUCCUSE  C OTHER ACCIDENT?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	C. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	
PBC PPD / TRADE JU-15-BCF2  READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S CR AUTHORIZED FERSON'S SIGNIATURE I authorize the release of any medical or other information necessary.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also redues) pryment of government benefits either to myself or to the porty who accepts assignment below	services described below
14. DATE OF CURRENT ILLUIESS, INJURY, & PREGNANCY (LMP) 15 OTHER DATE	SIGNED Y  16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM DD M
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	FROM TO  18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
17 Marshuallow 17b NPI TOLOW TO ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	FROM TO 20 CUTSIDE LAB? \$ CHARGES
21. DI AGNOSIS CRINATURE OF ILLIVESS CRINATURY Relate A-L to ser vice line below (24E) ICD Inc. 10	YES NO \$713
F107 BA12.3 CH60. BA13.2	123-125
1 F92.80 J M12.01 K F8 L 123  24 A DATE(S) OF SERVICE B C D PROCEDURES, SERVICES, OR SUPPLIES E	211701819BRA
From To RACEOF (Exclain Unusual Circumstances) DIAGNOSI: MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER	F. DAYS EPOT ID RENDERING PROVIDER ID # 10 NPI 368742249/ OUAL PROVIDER ID # 10 NPI 6183154247 EN 10 NPI 4289247212
1103181103181001A1601	640 00 1 NO 3687422491 5
11041840418 COAL01701	740501 1 6183154247 5
410718 110718 CO A 121812 2	86500 1 NPI 7289247212
411518111518100131218361	1630 50 1 1 6394213227 5
1120181412018 NMAL1907	12 630 30 1 NPI 639 42 (322 1 10 12 630 30 1 NPI 6 (322 1 492)
1213181213181241812005 1 2	127217
25 FEDERAL TAXID NUMBER SSN EN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? 98765432/ YES JINO	29 TOTAL CHARGE 29 AMOUNT PAID 30 Result for NUCC Use \$ 19,5/3 23 \$ 765 60
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bit and are made a part thereof.)  32. SERVICE FACILITY LOCATION INFORMATION  32. SERVICE FACILITY LOCATION INFORMATION  32. SERVICE FACILITY LOCATION INFORMATION  33. SERVICE FACILITY LOCATION INFORMATION  34. SIGNATURE OF PHYSICIAN OR SUPPLIER  INCLUDING DEGREES OR CREDENTIALS  (I certify that the statements on the reverse apply to this bit and are made a part thereof.)	23 BILLING PROVIDER INFO & PH ( )
Ln 12-1-18	CSG-A271315
SIGNED DATE a	a NEL a



PICA	PICA TT
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER ELKLUNG (ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	Ta. INSURED'S I D. NUMBER (For Program in Item 1)  26X123456789
2 PATIENT'S NAME (Last Name, First Name, Midde Initial) 3 PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MARTINI S ADDRESS (NO , Steet)  P. 09 08 92 M F X 6 PATIENT'S ADDRESS (NO , Steet)	ZOMO, SZRGEI H.
TOO'T TAM PO CO Rd Self Spouse Child Cher	300 Franken Fries St
Telecote NM	Carrer STATE WY
21PCCOE TELEPHONE (Indude Area Code) (6123(3-2101	82 60/ (21) 768-2169
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	Carrer WY 2 2 2 10 2 10 2 10 2 10 2 10 2 10 2 10
a. OTHER INSURED'S POLICY OF GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
227175 U YES NO NO DI AUTO ACCIDENT?	08 13 82 MX FL
19-05-923   XYES NO	a INSURED'S DATE OF BIRTH  MM   D   Y   M   F    b OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OF FROGRAM NAME  OVERY PPO  d ISTHERE ANOTHER HEALTH CENEFIT PLAN?
c HESERVED FOR NUCCUSE  C. OTHER ACCIDENT?  YES KNO	C. INSURANCE PLAN NAME OF FROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	1 1 2 2 2 2
AETWA PTX CLO (CE BC- +5 -A18  READ BACK OF FORM BEFORE COMPLETING & SKINNG THIS FORM.	YES NO Hyes, complete items 9, 9a, and 9d.  13 INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize
<ol> <li>PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE. Lauthorize the release of any medical or other information necessary to process this claim. Laiso request payment of government benefits either to myself or to the party who accepts assignment below.</li> </ol>	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15 OTHER DATE  OUAL S23  QUAL 190 790	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  FROM (O /9 / 1 / 10 / 02 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 /
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
17 Trankenburger 17 NPI NEWARK 19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	PROMIO ON DE TO O OT LE
PBB745-19 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	YES NO \$ (124
A LG 308 B L LZ3 C R13 9 D L J 3	22. RESUBMISSION CRIGINAL REF. NO 223A(2
ET 13 FL 10/19 GN31.2 HLASS.3	1987A12(4(67
24. A DATE(S) OF SERVICE B. C D. PROCEDURES, SERVICES, OR SUPPLIES E. From To RACEOF (Explain Unusual Circumstances) DIAGNOSIS	6 10 11 1
MM DD YY MM DD YY SERVICE EMG OPTHOPOS MODIFIER POINTER	
	1240:00 1 1 1 12348 6467 0
10 103 118 110 103 118 11 MM A 1341541 1 1	32015 1 NPI 725342978 6
101518 101518 NM - 1341591	24525 1 107802728 5
10/20/18/10/20/(8/NM/C/BU/85)   Z	1850 00 1 NPI 9237428231 5
	8 30 60 1
111318 111318 WMB 139002	42010 1 1 2(23243157
25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29, AMOUNT PAID 30 RSvd to NUCC Use
987-654-3210 = 37542121   YES NO	\$98,415 13 \$2673 12
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO 8 PH ( )
apply to this bit and are made a part thereof.)  Attout ta (Table 1)	1 Coms A13551
SIGNED LV17/18 a a	a NPI a



PICA	PICA TITLE
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER KLUNG (ID#) (ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	ZGN900123456 (For Program In Hern 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)  3 PATIENT'S BIRTH DATE  SEX  MM   DD   CYCLE  TO SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
S PATIENT'S ADDRESS (No., Sreet)  6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No. Steet)
9654 Sadness St. set & spouse Child Corner	9654 Saduezz St.
Shandon CA RESERVED FOR NUCC USE	Shandon CA
ZIP CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Indude Area Code)
9. OTHER INSURED'S NAME (Last Name, Rirst Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
JONES, BIB:	929512
a. OTHER INSURED'S POLICY OR GROUP NUMBER  A. EMPLOYMENT? (Qurrent or Previous)	a INSURED'S DATE OF BIRTH  MM   DD   VY   F   F   VY   F   F   VY   F   F   F   F   F   F   F   F   F
b RESERVED FOR NUCC USE  b AUTO ACCIDENT?  PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. OTHER ACCIDENT?	Shandon  ZIP CODE  TELEPHONE (Include Area Code)  9346/ 213)323-1517  11. INSURED'S POLICY GROUP OR FECA NUMBER  429512  a. INSURED'S DATE OF BIRTH  SEX  MM   DD    12   13   69   M
BB8-22D2 YES NO	BCBS of California
BCBS MASS PPO	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 CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary.	13. INSURED'S OF AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below	services described below.
SIGNED PATE (0 / 15 / 17	SIGNED
14 DATE OF CURRENT ILLUERS, TIJURY, OF PREGNANCY (LMP) 15 OTHER DATE  OUAL DRY  OUAL DRY  OUAL DRY  OUAL 12 OF 18	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MAIN DRAW DRAW DRAW DRAW DRAW DRAW DRAW DRAW
17 NAME OF REFERMING PROVIDER OR OTHER SOURCE 17a	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 CUTSIDE LAB? \$CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Retale. At to service line below (24E)	YES NO 8 765
A PST B LSI C KZZ I D O 02 1	22 RESUBMISSION CRIGINAL REF. NO Z (13797
E1717.11 FLADER GLUZ HG210	23. PRIOR AUTHORIZATION NUMBER SP3 1345638 A
24 A DATE(S) CF SERVICE B C D PROCEDURES, SERVICES, CR SUPPLIES E. (Explain Unusual Croumstances) DIAGNOSIS	F. G. H. I. J. DAYS EPOOT IN DENINERING
MM DD YY MM DD YY SERVICE EMG OPT/HCPCS MODIFIER POINTER	200   00   3   NPI 2123456789   3620   00   00   00   00   00   00   00
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	3620 00 3 NPI 2123436789
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1210/18/12/0/18/COIA/QQ492 3	
25 FEDERALTAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID 30 Psych for NUCC Use
999 - 998 - LZ34   LZ34 S6705   Ves   NO   31. SIGNATURE OF PHYSICIAN OR SUPPLIER   32. SERVICE FACILITY LOCATION INFORMATION	\$45,51717 \$ \$24 01 A20
INCLUDING DEGREES OR CREDENTIALS	33 BILLING PROMDER INFO & PH (AR)
(I certify that the statements on the reverse apply to this bit and are made a part thereof.)  A solution of the reverse apply to this bit and are made a part thereof.)	CSG- 1775
SIGNED DATE a a	a b.
NILIOO Instruction Manual and Indian	



PICA	PICA T
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP ECA OTHER EXAMPLE (Medicares) (Medi	1a INSURED'S I.D. NUMBER (For Program in Item 1)  ABC 4 \ 234567890
2 PATIENT'S NAME (Last Name, First Name, Midde Initial)  3. PATIENT'S BIRTH DATE  MM JDD  1.7 34 1956MV F	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Steel)
STATE IS RESERVED FOR NUCC USE	1127 Veryfake rd.
New York NY	Chicago STATE
12345 (816527 - 8153	76542 (312)(23-4567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  10. IS PATIENT'S CONDITION RELATED TO:	Chicago  ZIP CODE  TELEPHONE (Indude Area Code)  76542  (3(2)(23-4567)  11. INSURED'S POLICY GROUP OR FECA NUMBER  FECANUMB 3R  a. INSURED'S DATE OF BIRTH  O 7 1 8 1 19 2 2 M  D OTHER CLAIM ID (Designated by NUCC)  A 1 2 3 4 5 6 7 8  C INSURANCE PLAN NAME OR PROGRAM NAME  ACME INSURANCE PLAN NAME OR PROGRAM NAME
a. OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  ZYX 0987654321	a. INSURED SDATE OF BIRTH  O 7 N
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCCUSE  c. OTHER ACCIDENT?	c INSURANCE PLAN NAME OF PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME 10d, CLAIM CODES (Designated by NUCC)	ACME INSURANCE
Doesn't Exist Insurance CODEZ	YES NO Hyes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S CRIAUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I glicy request payment of government tenefits after to myself or to the party who accepts assignment.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described before.
SIGNED	SIGNED JAmes
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE	16 DATES PATIES ONABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.	FROM OG 4 1920 TO 07 18 1989  18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM DD  YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	FRCM (2 12 20(2 TO 09 18 2019 20 OUTSIDE LAB? \$CHARGES
This is additional information	YES XNO   5000   00
21. DIAGNOSIS OR NATURE OF ILLNESS CR INJURY Relate AL to service line below (245)  A L	CRIGINAL PEE NO 78910
EL GL HL	23. PRICE AUTHORIZATION NUMBER
24. A DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES E. PROM TO RACEOF (Explain Unusual Circumstances) DIAGNOSIS	F. G. H. I.  DAYS EPOT ID RENDERING COMMISSION OF SCHARGES UNITS AND QUAL PROVIDER ID. #
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS   MODIFIER POINTER	\$ CHARGES UNITS Ran QUAL PROVIDER ID. #
01/02/20 03/03/21/A/3/Not	100G 25 5 NPI 12345678
0211 15 04 04 22 B   sure	2000 87 32 NPI Q10111234
03/12/18/05/16/23/C/ what	3356 22 83 NPT 15161789
04/13/06/06/19/32/DI this	SCHARGES DATS PROVIDER ID S SCHARGES UNITS RATION OUAL PROVIDER ID S  1000   25   5   NPI (2545678   2000   87   32   NPI Q 10 1(1234   3356   22   83   NPI   15 [6 1789   4178   65   106   NPI   102   2223   5099   88 218   NPI 4586 19
05/14/02/07/21/46/E one	15099 88 218 10 458619
15 15 03 08 30 56 F   means	199999 799999
25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (FOR DAY CHARSES SEE BLOCK)	28 TOTAL CHARGE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS  32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
(i certify that the statements on the reverse apply to this bill and are made a part thereof.)	
SIGNE DATE 9/13/2 a	a 0.
NUCC detruction Manual available at: www.nucc.org	APPROVED CMB-0938-1197 FORM 1500 (02:12)



PICA	PICA [TT]
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  (Medicards) (Medicards) (Medicards) (ID\$/DoD\$) (MamberD\$) (ID\$/D (ID\$) (ID\$)	1 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 SEX	LEG4-TE5-MK72 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Franklin, Ben 10 18 60 MX FL	SAME
5. PATIENT'S ADDRESS (No., Street)  6. PATIENT'S ADDRESS (No., Street)  5. PATIENT'S ADDRESS (No., Street)  6. PATIENT'S ADDRESS (No., Street)  Cather	7. INSURED'S ADDRESS (No., Street)
CITY STATE B RESERVED FOR NUCC USE	CITY STATE
BOSTON MA  ZIP CODE TELEPHONE (Indude Alea Code)	
02108 ( )	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle billal) 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? (Ourrent or Previous)	ZIP CODE  TELEPHONE (Include Area Code)  ( )  11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH  MM   DD   YY   M
YES NO	a INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
C RESERVED FOR NUCCUSE C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	<u> </u>
ID. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	YES NO #yes, complete items 9, 9a, and 9d.  13. INSURED'S CR AUTHORIZED PERSONS SIGNATURE   authorize
12 PATIENT'S CRI 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.	payment of medical benefits to the undersigned physician or supplier for services described below
SIGNED Ben Frankley DATE 10-1-2019	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	FROM TO
I.M. Prescribing Proudents NO OILLIII	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to ser wor line below (24E)	YES NO 22. RESUBMISSION
A 51907 B C D	CODE CRIGINAL REF. NO.
E G H	23. PRICE AUTHORIZATION NUMBER
I.   K.   L   L   L	F. G H. I. J
From To RIACEOF (Explain Unusual Orcumstances) DIAGNOSIS  MM DD YY MM DD YY SBRVCE EMG CPT/HCPCS   MCOIFIER POINTER	S CHARGES UNITS PAR OUAL PROVIDER ID.
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	1 191
25 FEDERALTAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (FOR POAR CLAIM), see big 1)	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd.for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER  32 SERVICE FACILITY LOCATION INFORMATION	\$ 3500 00 \$ 0 00
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	LM. Provider
a pply to this bill and are made a part thereof)	IN WILLIAMS SI
SIGNED DATE a b	Boston, MA 0210K
NLICC Instruction Manual available of www.ruce.org	



PICA PICA	11 (1000) 02112	PICA TTT
MÉDICARE MEDICAID TRICARE  (Medicares) (Medicaids) (ID\$/DoD\$)	HEALTH PLAN BLK LUNG	1 12 INSURED'S LD NUMBER (For Program in Hern 1)
(Medicards) (Medicalds) (ID\$/DoD\$)  2 PARENT'S NAME (Last Name, First Name, Middle Inits)	(Mamber ID4) (ID4) (ID4) (ID5) (ID5)	4 INSVIRED'S NAME (Last Name, First Name, Middle Initial)
Pat Sajak	10 10 1905 ME F	Alex Trebek
5 PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED  Self Spouse Think Other	596 Drive Avenue
CITY	STATE 8 RESERVED FOR NUCC USE	
ZIP CODE TELEPHONE (Indude		ZIP CODE TELEPHONE (Include Area Code)
12345 (785) 555		63188 (123)7891010
9. OTHER INSURED'S NAME (Last Name, First Name, Mr. VERNA White	Iddle Initial) 10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER 777111722
a. OTHER INSURED S POUCY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
	YES X NO	, and the second
c RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	ZIP CODE TELEPHONE (Include Area Code)  G3 1 8 8 (123) 7 89 1010  11. INSURED'S POLICY GROUP OR FECA NUMBER  777   11 2 2 2  a. INSURED'S DATE OF BIRTH MM   DD   YY   10   13   1487   M   X   F    b. OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OR PROGRAM NAME  10   COU   VIA  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFOR	RE COMPLETING & SIONING THIS FORM.	YES X NO #yes, complete Items 9, 9a, and 9d.  13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE Lauthorize
12 PATIENT'S CR AUTHORIZED PERSON'S SIGNATUR to process fils claim and request payment of government below	RE I authorize the release of any medical or other information necessary entitlements either to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described benefits.
SIGNED (19 WW	DATE [2/12/10/2	SIGNED / MNLL
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNAM		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOU		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Healthan, gov 19. ADDITIONAL CLAIM INFORMATION (Designated by P	17b NPI	FROM 65 10 20 TO 05 10 20
19. ADDITIONAL CLAIM INFORMATION (Designated by F	NUCC)	20. CUTSIDE LAB? \$CHARGES
21. DIAGNOSIS OF NATURE OF ILLNESS OF INJURY F	Relate A-L to ser vice line below (24E) ICD Ind	22. RESUBMISSION
A.L	. c o	23. PRIOR AUTHORIZATION NUMBER
J. L. J. L.	к	(0° C)
24. A. DATE(S) OF SERVICE   B.   From To R. ACE OF MM DD YY MM DD YY SERVICE   EI	C D. PROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Orcumstances) DIAGNOSIS EMG OPT/HCPCS   MODIFIER POINTER	F. G. H. I. DAYS EPDT ID RENDERING CR Famey SCHARGES UNITS Fam QUAL PROVIDER ID. #
	ABC	1000 00 1
		NPI
16 17 20 11 38 156	DEF	2500 (0) L NPI
06 16 01 12 99 50	HET	1750 100 3 NPI
02 17 93 66 47 94	LMNO	1900 16 4 NPI
2. 2. 400 0 -		NPI NPI
04 (5 97 65 15 99	Pass	1 00 5 NPI
61 33 45 12 34 8	The	NPI NPI
2214661624 A-	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?  LILI YES NO.	28 TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd. for NUCC Use \$ 60, 666 00 \$ 0 00
31, SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE FACILITY LOCATION INFORMATION	36 0, 66 C 00 \$ 0 00 00 00 00 00 00 00 00 00 00 00
INCLUDING DEGREES OR CREDENTIALS (I certly that the statements on the reverse apply to this bill and are made a part thereol.)	Everywhere, 494	` *
	,	
SIGNED DATE	a a	a NET b
NUCC instruction Manual available at: www.i	nucc.org PLEASE PRINT OR TYPE	APPROVED CMB-0938-1197 FORM 1500 (02-12)