

PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 112/12			PICA ITT
MEDICARE MEDICAID TRICARE CHAMPVA	GROUP FECA OTHER	1a INSURED'S I.D. NUMBER	(For Program in Item 1)
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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
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31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO 8 PH (636) 581-346 8
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NUCC Instruction Martinal available at: www.nucc.org PLEASE PRINT OR TYPE	APPROVED CMB-0938-1197 FCRM 1500 (02-12)



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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S CR AUTHORIZED PERSON'S SIGNATURE 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 suppler
to process this claim. It also request payment of government benefits either to myself or to the party who accepts assignment below.	services described below
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NAME OF REFERRING PROMIDER OF OTHER SOURCE 17a	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER BUX LUNG OTHER BUX LUNG (Medicares) (Medicards) (IDS/DODS) (Member IDS) (IDS) (IDS)	1a. INSURED'S I.D. NUMSER (For Program in Nem 1)
2 PATIENT S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
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5 PATIENT S'ADDRESS (No., Steel) 6 PATIENT RELATIONSHIP TO INSURED 927 Set Spouse Child Cther	42713 Steet Dr
Spring Field STATE 8 RESERVED FOR NUCCUSE	Springfield STATE
ZIP CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHOTIE (Include Area Code)
65732 (213) 555 - 1145 9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO	65431 (2/3) 555 1145
5 OTTERTHOOTED STREET (CENTRAL CENTRAL	123454567
a OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
b RESERVED FOR NUCC USE b AUTO ACCIDENT?	b OTHER CLAIM ID (Designated by NUCC)
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c. RESERVED FOR NUCCUSE C. OTHER ACCIDENT? YES X NO	TELEPHONE (Include Area Code) (213) 555 1145 11 INSURED'S POLICY GROUP OR FECA NUMBER 1 23454567 a INSURED'S DATE OF BIRTH OS 19170 M FX b OTHER CLAIM ID (Designated by NUCC) c INSURANCE PLAN NAME OR PROGRAM NAME My Home State Health 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? YES X NO // yes, complete items 9, 9a, and 9d
READ BACK OF FORM BEFORE COMPLETING A SIGNING THIS FORM. 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
to process his claim. I also request payment of government benefits either to myself or to the porty who accepts assignment below.	payment of medical benefits to the undersigned physician or supplier for services described below
SIGNED DATE	SIGNED
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15 OTHER DATE MM DD YY OUAL MM DD YY OUAL DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
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19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20 CUTSIDE LAB? \$ CHARGES
21 DIAGNOSIS CRINATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind	22 RESUBMISSION CRIGINAL REF NO
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24. A DATE(S) OF SERVICE B C D PROCEDURES, SERVICES, CR SUPPLIES E. From To RACEOF (Explain Unusual Croimstances) DIAGNOSIS MM DD YY MM DD YY SRWCE EMG CPTHCPCS MODIFIER POINTER	F G H, 1 J DAYS EPSUT ID. RENDERING S CHARGES UNITS For QUAL PROVIDER ID.
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25 FEDERAL TAX I D NUMEER SSN EIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT (FOT gOST CLAIMS, See Bad.)	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use
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1 MEDICARE MEDICAID TRICARE X (Medicare#) X (Medicaid#) (10#/0c0#)	CHAMPVA GROUP FECA OTHER (Member IDs) (IDs) (IDs)	R 1a INSURED'S I.D NUMBER (For Program in Hem 1) スタイク50よ3
2. PATIENT'S NAME (Last Name, First Name, Middle Initia		4 INSURED'S NAME (Last Name, First Name, Middle Initial)
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9 OTHER INSURED'S NAME (Last Name, First Name, Mi		11 INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	1234 SNSC7 a INSURED'S DATE OF BIRTH SEX
	YES XNO	05 14 70 M F F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
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- 10.00000000000000000000000000000000000	YÉS KO	My Homestak Wealth
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CCDES (Designated by NUCC)	
READ BACK OF FORM BEFOR	RE COMPLETING & SIGNING THIS FORM.	YES NO // yes, complete frems 9, 9a, and 9d 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12 PATIENT'S CH AUTHCHIZED PERSON'S SIGNATUR: to process this claim. I also request payment of governme below.	iE il authorize the release of any medical or other information necessary entitienetits either to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below
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17 NAME OF REFERRING PROVIDER OR OTHER SOUL	OUAL	FRCM TO
I Maile of Her English of House Scot	IRCE 17a 17b NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO TO FROM TO TO TO THE PROPERTY OF THE PROPERTY
19 ADDITIONAL CLAIM INFORMATION (Designated by N	ucc)	20 OUTSIDE LAB? \$ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY F	Relate A-L to service line below (24E)	YES NO
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25 FEDERALTAXID NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use
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NUCC instruction Manual available at www.r	nucciorg PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-12)



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTE	王 (NUCC) 02/12	700
1. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTH	PICA PICA PICA PICA PICA PICA PICA PICA
(Medicare#) (Medicald#) (ID#/DoD#)	CHAMPVA GROUP FECA OTH HEALTH PLAN BUK LUNG (ID#) (ID#)	
2 PATIENT'S NAME (Last Name, First Name, Middle Init	T PATIENT'S BIRTH DATE SEX	Padde initial)
5 PATIENT'S ADDRESS (No., Steet)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Steet)
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9 OTHER INSURED'S NAME (Last Name, First Name, N	/iddle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHED HEALTH BENEFIT PLAN? YES NO #yes, complete tiens 9, 9a, and 9d
12 PATIENT'S CR AUTHORIZED PERSON'S SIGNATUI	THE COMPLETING A SIDNING THIS FORM. RE I authorize the release of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize
to process this claim. I also request payment of government of the control of the	nent benefits either to myself or to the party who agrepts assignment	services described twow
SIGNED	NCY (LMP) 15. OTHER DATE	SIGNED and in Kappe
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17. NAME OF REFERRING PROVIDER OR OTHER SOL	JRCE 17a 17b NPi	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 02 1 28 9 3 TO 01 01 9 3
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a poly to this bill and are made a part thereof)	New Berlin, MO 65894	Eleanor, CA 78453
SIGNED DATE	a NPI b	a NP b
Ni ICC Instruction Manual available at www	DUCC ORG. DI FASE DRINT OR TYPE	APPROVED OME-0938-1197 FORM 1500 (02-12)



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O	ance T	,	05 04	l I at YY		apper. Ch		e, moure mas	±u}
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Chicago	TELEPHONE (Indud	Area Code)			710	hicago	TO COUG	NE (Include A	<u>JL</u>
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below	<i>T</i>	nicin Concins Sales	aniyacii di ka ke	party with accepts assignme	sit s	services described belo	.₩		
SIGNED Chance	. The K	apper	DATE	11/18/05		SIGNED Cha	nce Th	e Ro	sper
14. DATE OF CURRENT ILLNESS	, INJURY, or PREGN.		THER DATE	MM DD YY		DATES PATIENT UNA	BLE TO WORK IN	CURRENT O	CCUPATION
08 03 92 OJ		QUA				RCM 02 09		· 02	
17, IVANIE OF HERENBING PAON	IDEN ON OTHER SC		NPI			FROM 02 28	YY	MW, E	אין סכ
		77.2	1111		1	OL LO	י כד	004 0	6 17.3
19. ADDITIONAL CLAIM INFORM	ATION (Designated by	NUCC)				OUTSIDE LAB?		CHARGES	
						OUTSIDE LAB?	\$		
19. ADDITIONAL CLAIM INFORM. 21. DIAGNOSIS CRINATURE OF			e line below (24)	E) ICD Ind	20 (22 F		\$	0.0	,S
21. DIAGNOSIS OR NATURE OF			te line below (24)	E) ICD Ind	22 E	YES X NO RESUBMISSION CODE	\$ CRIGINAL	0.0	
	ILLNESS OR INJURY		reline below (24)	ICO Ind	22 E	YES X NO	\$ CRIGINAL	0.0	
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) OF SERVICE	BL	Relate A-L to servic C-L G-L K-L		ICO Ind	22 E	YES NO NESUBMISSION CODE	CRIGINAL CN NUMBER	0.0	
21. DIAGNOSIS CR NATURE OF A L E L I L	B. L. P. L.	Pelate A-L to service C L G L K L C: D PRIOCEL	OURES, SERVIC	D L L ES, CR SUPPLIES DIA	22 f	YES NO	CRIGINAL CN NUMBER	D.C	,S
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A. DATE(S) CF SERVICE From TC MM DD YY MM DD	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER	D.C	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) OF SERVICE From To	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER	PREF. NO.	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TC MM DD YY MM DC	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G H I. ANYS EPROT ID ANYS PROTEIN OUA	D. C	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TC MM DD YY MM DC	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G H I. PROT ID PROT ID NITS PROT QUA	D. C	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A. DATE(S) CF SERVICE From TC MM DD YY MM DD	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G H I. ANYS EPROT ID ANYS PROTEIN OUA	PEF. NO.	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TC MM DD YY MM DD	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G H I. NAYS EPOT ID. CR Farity ID. NITS Ran QUA	PEF. NO.	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TC MM DD YY MM DC	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G H I. NAYS EPOT ID. CR Farity ID. NITS Ran QUA	PEF. NO	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TC MM DD YY MM DC	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G H I. PROT ID PROT ID NPI	PEF. NO	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TC MM DD YY MM DC	B. L. B. R. ACE OF J. Y.Y. SERVICE	Relate A-L to ser Mo C L G L K L C D PROCE EXPLAINE EMG CPT/HCPC	DURES, SERVIC 1 Unusual Ordun 2S	ES, CR SUPPLIES Instances) DIA MODIFIER P.0	22 f	YES NO	CRIGINAL CN NUMBER G. H. I. ANYS EPSOT ID CR Farity QUA NPI	PEF. NO	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From TV MM DD YY MM DO 12 S 99 02 0	B. L. B. P. ACEGF. YY SERVICE	Pelale AL lose wo	DURES, SERVIC 1 Unusual Oraum S 21	ES, CR SUPPLIES Instances) MODIFIER P.0	22 F 23 F E.GNOSIS DIVTER	PRICE AUTHORIZATI F	CRIGINAL CN NUMBER G H I. PROT ID PROT ID NPI	PR PR	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From Tr MM DD YY MM DD 12 S 99 02 0	B. B. R.ACEOF. YY SERVICE SSN &N	Pelale AL lose wo	DURES, SERVICE Onusual Oran S 21	ES, CR SUPPLIES Instances) DIA MODIFIER PC	22 F E. GNOSIS DITTER STATE ST	PRICE AUTHORIZATI F S CHARGES L TOTAL CHARGE	CRIGINAL CN NUMBER G H I. SAYS EPOT IO CA FAMILY IO NITS PAR OUA NPI NPI NPI NPI NPI NPI NPI NP	PAID 30	J RENDERING
21. DIAGNOSIS CR NATURE OF A L E L 1 24 A DATE(S) CF SERVICE From TV MM DD YY MM DT 12 S 99 02 0 12 S FEDERAL TAX I D NUMEER 458-78-887	B L B PLACEGE YY SERVICE	Pelale AL lose vo	DURES, SERVIC In Unusual Crain S 21	ES, CR SUPPLIES INSTANCES) MODIFIER 27 ACCEPT ASSIGNATION OF THE PROPERTY OF	E. CONTER STANDARD ST	PRICE AUTHORIZATI F. S. CHARGES L. TOTAL CHARGE 2 01	CRIGINAL CN NUMBER G H I. NAYS EPODT IO CR Family IO NITS Ran QUA NPI NPI NPI NPI 1 NPI NPI 1 NPI NPI 1	PAID 30	J. BENDERING OVIDER ID. #
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From DD YY MM DT 12 S 99 02 0 12 S FEDERAL TAX I D NUMEER 458-78-887 31 SIGNATURE OF PHYSICIAN O INCLUDING DEGREES CR CF	B. PLACE OF SERVICE SSN EN OR SUPPLIER REDEFILALS	Pelale AL lose wo	DURES, SERVIC In Unusual Oram S 21	ES, CR SUPPLIES Instances) DIA MODIFIER PC	22 F 23 F E. GNOSIS DINTER 9	PRICE AUTHORIZATI F. S. CHARGES L. TOTAL CHARGE BILLING PROVIDER IN	CRIGINAL CN NUMBER G H I I I I I I I I I I I I I I I I I I	PAID 30	J. BENDERING OVIDER ID. #
21. DIAGNOSIS CR NATURE OF A L E L 1 24 A DATE(S) CF SERVICE From TY MM DD YY MM DO 12 S 99 02 0 25 FEDERAL TAX I D NUMBER 458-78-887 31 SIGNATURE OF PHYSICIAN OF	B L B PLACEGE YY SERVICE SON EN SER SUPPLIER REDBITIALS the reverse	PRIAD AL DIST NO. C L G L K, L C. D PROCEE (Explain EMG CPTHCPC 55 9921. 26 PATIENT'S AI 549 67 32 SERVICE FAC IS 8Th	DURIES, SERVIC In Unisual Orani S 21 3 21 CCOUNT NO. 1026 BILTY LOCATIO	ES, CR SUPPLIES Instances) ES, CR SUPPLIES INDOMER DIA MODIFIER DIA MODIFIER P.C 27. ACCEPT ASSIGNI (For gove chams, see b) X YES NO N INFCRIMATION	22 F 23 F E. GNOSIS DINTER 9	PRICE AUTHORIZATI F. S. CHARGES L. TOTAL CHARGE BILLING PROVIDER IN	CRIGINAL CN NUMBER G H I I I I I I I I I I I I I I I I I I	PAID 30	J. BENDERING OVIDER ID. #
21. DIAGNOSIS CR NATURE OF A L E L 1 24 A. DATE(S) CF SERVICE From Tr MM DD YY MM DT 12 S 99 02 0 12 S PEDERAL TAX I D NUMEER 458-78-887 31 SIGNIATURE OF PHYSICIAN (INCLUDING DEGREES CR CF (I certify that the statements on the content of the certify that the statements on	B L B PLACEGE YY SERVICE SON EN SER SUPPLIER REDBITIALS the reverse	PRIAD AL DIST NO. C L G L K, L C. D PROCEE (Explain EMG CPTHCPC 55 9921. 26 PATIENT'S AI 549 67 32 SERVICE FAC IS 8Th	DURIES, SERVIC In Unisual Orani S 21 3 21 CCOUNT NO. 1026 BILTY LOCATIO	ES, CR SUPPLIES INSTANCES) MODIFIER 27 ACCEPT ASSIGNATION OF THE PROPERTY OF	22 F 23 F E. GNOSIS DINTER 9	PRICE AUTHORIZATI F. S. CHARGES L. TOTAL CHARGE 2 01	CRIGINAL CN NUMBER G H I I I I I I I I I I I I I I I I I I	PAID 30	J. BENDERING OVIDER ID. #
21. DIAGNOSIS CR NATURE OF A L E L 1 L 24 A DATE(S) CF SERVICE From Tr MM DD YY MM DT 12 S 99 02 0 12 S 99 02 0 15 FEDERAL TAX I D NUMBER 458-78-887 31 SIGNATURE OF PHYSICIAN (INCLUDING DEGREES CR CF (I certify that the statements on	B. B. R. ADE GF SERVICE SSN EN PREDENTIALS The reverse a part thereof) DATE	PRIAD AL DISTING C L G L K L C D PROCEE (Explain EMG CPT/HCPC SS 9921. 26 PATIENT'S AI 54967 32 SERVICE FAC IS 8Th New Be a	DURIES, SERVIC In Unisual Orani S 21 3 21 CCOUNT NO. 1026 BILTY LOCATIO	ES, CR SUPPLIES Instances) ES, CR SUPPLIES INDOMER DIA MODIFIER DIA MODIFIER P.C 27. ACCEPT ASSIGNI (For gove chams, see b) X YES NO N INFCRIMATION	22 F 23 F E. GNOSIS DINTER 9	PRICE AUTHORIZATI F. S. CHARGES L. TOTAL CHARGE BILLING PROVIDER IN	CRIGINAL CN NUMBER G H I I I I I I I I I I I I I I I I I I	PAID 30	J. BENDERING OVIDER ID. #



PICA			PICA TT
1. MEDICARE MEDICAID TRICARE CHAMPV	- HEALTH PLAN - BEKLUNG	1a, INSURED'S I.D. NUMBER (For Program	n in Item 1)
(Medicare#) (Medicare#) (ID#/DoD#) (Member II 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		329843023498	
Doc John 1	3. PATIENT'S BRITH DATE SEX	1 INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John 1	
5 PATIENT'S ADDRESS (No., Steet)	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Steet)	
1234 Example Street	Self Spouse Child Other	1234 Example Street	
CITY STATE	B. RESERVED FOR NUCC USE	СПУ	STATE
St. Louis MO		St Lavis	Mo
ZIP CODE TELEPHONE (Indude Area Code) (123) 1234567		ZIP CODE TELEPHONE (Indude Area	(Code)
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	63141 (123) 1234	1961
		2343DFSD	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Ourrent or Previous)	a INSURED'S DATE OF BIATH SEX	
A DECEMBED FOR All COLLIGE	YES NO	1 1 60 MX	F L.
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	
	TYES NO	Medicare	
d. INSURANCE PLAN NAME OF FROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?	MO a Code) 1567
		YES X NO #yes, complete items 9, 9a, a	
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize he	release of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSONS SIGNATURE I payment of medical benefits to the undersigned physician or	
to process this claim. I also request payment of government benefits either below.	to myself or to the party who accepts as signment	services described below	ii suppler to
SIGNED John Doe	DATE 8/21/2019	SIGNED John Doe	
	OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCURRENT OCC	UPATION
08 21 2019 WAL asolfosa ON	AL MM DD YY	FRCM 08 21 2019 TO 05 28	2019
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178		18 HOSPITALIZATION DATES RELATED TO CURRENT SET	
FI DOCTOR PRODE	NPI NPI	FROM 08 21 2019 TO 88 25	2019
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 CUTSIDELAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	ce line below (24É)	YES NO 1700 00	2
1631.81 BI CL	ICD Ind	22 RESUBMISSION CRIGINAL REF. NO	
EL F.L GL		23 PRIOR AUTHORIZATION NUMBER	
<u>т. Е </u>	E. L		
From To RACEOF (Expla	DURES, SERVICES, CA SUPPLIES E. in Unusual Oroumstances) DIAGNOSIS	F. G H. I DAYS EPSUT ID. REN SCHARGES UNITS Part COAL PROM	J IDERING
MM DD YY MM DD YY SERVICE EMG CPT/HCP	CS MODIFIER PONTER	\$ CHARGES UNITS Ran CUAL PROV	IDERING IDER ID.
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		100 10 10 10 10 10 10 10 10 10 10 10 10	, 1311
		NPI	
			19319
		NPI	
		NPI NPI	
	1 1 1 1	I NPI	
		NPI	
25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S /		NPI CHARDE	
25 FEDERAL TAX 10 NUMBER SSN EIN 26 PATIENTS / 23948	tror dov. Chims, see Dack)		and for NUCC Use
	3929 XYES NO	\$ 1700 00 \$ 1660 00 33 BILLING PROVIDER INFO & PH# (122) 164	7000
INCLUDING DEGREES OR CREDENTIALS		1/63/43/	1878
	al Way	1 Billing Way St Louis, MO 12345	
St Louis	s, MO 12345	7+ COUIS, MD 12547	
SIGNED DATE a	ь	a NPJ b.	



TTTPICA	BICA CTTT.
	OTHER 1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicares) (Medicards) (IDS/DoDs) (IMember IDS) (IDS)	(D) 32984302349 <i>8</i> 1
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
5 PATIENT SALDRESS (No., Steet) 6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No. Szeet)
1234 Example Street Sell X Spouse Child Other	123 Example Street
STATE B RESERVED FOR NUCC USE	CITY STATE MO ZIP CODE S3/41 TELEPHCNIE (Indude Area Code) (123) 123 4567 TELEPHCNIE (Indude Area Code)
ZIP CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Indude Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO	D 11. INSURED'S POLICY GROUP OF FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Outrent or Previous)	2343 D T S D
YES NO	a INSURED'S DATE OF BIRTH SEX A
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
YES NO	Medicare
d INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CCDES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO #yes complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM, 12 PATIENT'S CRIAUTHCRIZED PERSON'S SIGNATURE I authorize the release of any medical or other information neces	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned chysician or supplier for
to process this claim. (also request payment of government benefits either to myself or to the party who accepts assignment below.	serwas described below
SIGNED_JOHN DOC DATE 8/2//20	19 SIGNED JOHN LOC +
14 DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15 OTHER DATE MM DD YY O'2 2 2 3 0 0 0 0 0 0 0 0 0	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 12 1 2019 TO 12 2019
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	FROM (X) 7 (2019 TO 08 25 2019 20 OUTSIDE LAB? \$ CHARGES
	YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	22 RESUBMISSION CRIGINAL REF NO
	23. PRICR AUTHORIZATION NUMBER
t. L. K. L.	
From To PLACE (Explain Unusual Croumstances) DIAG	E. F. G. H. I. J. DAYS EPOT ID RENDERING ONTER \$ CHARGES UNITS PLUT QUAL PROVIDER ID. #
08/21/19 108/25/19/1/05/4/13/034/	1700 00 1 N 1245319399 5
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	He was the second secon
	S S S S S S S S S S S S S S S S S S S
	PH-Y COAN COAN COAN COAN COAN COAN COAN COAN
	N9 N
	Harrier Harrison
25 FEDERAL TAX I D NUMBER SSN BIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNM	ENT? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC Use
123456798 X 239483 929 XYES NO	\$ 1700 00 \$165000
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse (I certify that the statements on the reverse	33 BILLING PROVIDER INFO & PH# (123 4567898
INCLUDING DEGREES CRICREDENTIALS (I certify that the statements on the reverse a poly to this bill and are made a part thereof) I Hospital Way St. Louis, MO 12345	1 Billing Way St. Louis, MO 12345
a NICL D	51.LOUIS//NO 12377
SIGNED DATE " DI FASE DEINT OR TYPE	ADDROVED ONE DORS 1107 ECHEL 1500 (CC. 12)



PICA	PICA TTT
1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER Medicares (Medicards) (IDs/DoDs) (Member IDs) (IDs/) (IDs/) (IDs/) (IDs/)	1 a. INSURED'S I D. NUMSER (For Program in Item 1)
2 PATIENT S NAME (La Warne, First Name, Ladde Initial) 3. PATIENT'S BIRTH DATE SEX M. F. I.C. 0'3 M. F.	4 INSURED'S NAME Cast Name, First Name, Modifie Initial)
5 PATIENT S ADDRESS NA Steet) 6. PATIENT RELATIONSHIP TO INSURED Set Spouse Child Other	42 Mx laby Wxu
CITY STATE 8. RESERVED FOR NUCC USE	STATE, STATE,
ZIPTULE TELEPHONE (Include Area Code)	ZIP CLOE TELEPHOTIE (Independe a Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OF FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current or Previous)	a INSDRED'S DATE OF BRITH SEX
b RESERVED FOR NUCC USE b AUTO ACCIDENT? PLACE (Sate)	ZIP CODE TELEPHONE (Inchrost the Code) TELEPHONE (Inchrost t
c RESERVED FOR NUCCUSE c. OTHER ACCIDENT?	S INSURANCE PLAN NAME OR PROGRAM JAME
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CODES (Designated by NUCC)	d ISTHERE ANOTHER HEALTH BENEFIT PLANT
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	YES NO If yes, complete items 9, 9a, and 9d.
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process his claim. I also request payment of government benefits either to myself or to the party who accepts adsignment below.	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 Nemo FINA DATE 5/17/18	SIGNED MERINYINN
14 DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15 OTHER DATE OUAL MM DD YY OUAL VY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DO TO
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI	18. HOSPI AUZATICA DATES RELATED TO CURRENT SERVICES MM DD TO 4 / 2 / 4
19 ADDITIONAL CLAIM INTORMATION (Designated by NUCC)	20 CUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICO Ind	22 RESUBMISSION CRIGINAL REF. NO
E	23 PRICE AUTHORIZATION NUMBER
I. J. K. L. L.	F. G H. I. J. PAYS EPOT ID RENDERING O
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER	\$ CHARGES DAYS FROM ID RENDERING OF FROM COAL PROVIDER ID. #
125 99 28 00 11 55 99213 21	305.88 NPI
	NPI
	NPI NPI
	\$ CHARGES ON RATE PROTECTION OF RENDERING PROVIDER ID. #
	NPI NPI
	1 NPI
25 FEDERAL TAX ID NUMEER SSN EIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT? 487-89-4578 \(\bar{x}\) 357634 \(\bar{x}\) YES NO	29 TOTAL CHARGE 29 AMOUNT PAID 30. Rsvd. for NUCC Use \$ 21.52 US \$ 0.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse)	33 BILLING PROVIDER INFORPHO (58745789627
including degrees of credentials (certly that the statements on the reverse apply to this bill and are made a part thereof) 7041, C/0R 43267	Witenfoll, AK 44573
SIGNED DATE a	a NI b