HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 329843023498

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

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

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

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

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

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

CITY: St Louis | STATE: mo

8. RESERVED FOR NUCC USE

CITY: St Louis | STATE: mo

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

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

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

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2343DFSD

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH: MM 1 DD 1 YY 60 SEX: M [X] F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED John Doe DATE 8/21/2019

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

SIGNED John Doe

PATIENT AND INSURED INFORMATION

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

15. OTHER DATE: QUAL MM DD YY

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

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

17a

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES: 1700.00

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

A. G31.81 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	08	21	19	08	25	19	Hos	Y	B4034			1700.00	1	N	NPI	1245319399
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO.: 239483929

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

28. TOTAL CHARGE: $ 1700.00

29. AMOUNT PAID: $ 1650.00

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
1 Hospital Way
St Louis, MO 12345

a NPI b

33. BILLING PROVIDER INFO & PH # (123) 4567898
1 Billing Way
St Louis, MO 12345

a NPI b

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 316354Y32

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

3. PATIENT'S BIRTH DATE: MM 07 DD 28 YY 69 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1920 ImRich Lane

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

7. INSURED'S ADDRESS (No., Street): 1920 ImRich Lane

CITY: Hollywood | STATE: CA

8. RESERVED FOR NUCC USE

CITY: Hollywood | STATE: CA

ZIP CODE: 89575 | TELEPHONE (Include Area Code): (888) 5712597

ZIP CODE: 89575 | TELEPHONE (Include Area Code): (888) 5712597

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: thdhku77

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: MM 07 DD 28 YY 69 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: IronMan Health

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Tony Stark DATE: 7/28/09

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

SIGNED: Tony Stark

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 11 DD 01 YY 2013 QUAL: bad

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 07 05 2014 TO 05 08 2025

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Vision RedMan

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 04 12 2007 TO 04 12 2030

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

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

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

A. E00-E90 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09	12	00	09	25	00	ER	11	99213	21		1200.87			NPI	1245319599
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

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

26. PATIENT'S ACCOUNT NO.: tL66ku8

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

28. TOTAL CHARGE: $ 55.87

29. AMOUNT PAID: $ 2.23

30. Rsvd for NUCC Use:

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
53547 Lurry Lane
Tegan, NY
55555

a. b.

33. BILLING PROVIDER INFO & PH # (653) 3543248
Lemonpop Blvd
RaLeigh, NC
35165

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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): 316354732

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 28 69 SEX: M [ ] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1920 ImRich Lane

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

7. INSURED'S ADDRESS (No., Street): 1920 ImRichLane

CITY: Hollywood | STATE: CA

8. RESERVED FOR NUCC USE

CITY: Hollywood | STATE: CA

ZIP CODE: 89575 | TELEPHONE (Include Area Code): (888) 5712597

ZIP CODE: 89575 | TELEPHONE (Include Area Code): (888) 5712597

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: thdhku77

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 07 28 69 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: IronMan Health

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Tony Stark DATE: 7/28/09

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

SIGNED: Tony Stark

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 09 2013 QUAL: bad

15. OTHER DATE QUAL: MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 07 05 2014 TO 05 01 2025

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Vision RedMan

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 04 12 2007 TO 01 12 2030

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

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

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

A. E00-E90 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER:

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL	J RENDERING PROVIDER ID. #
1 09 12 00	04 25 00	ER	11	99213	21		1200.87	1		NPI	1245319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: tL66ku8

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

28. TOTAL CHARGE: $ 55.87

29. AMOUNT PAID: $ 2.23

30. Rsvd for NUCC Use:

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

SIGNED: DATE:

32. SERVICE FACILITY LOCATION INFORMATION: 53547 Lurry Lane, Tegan, NY 55555

a. b.

33. BILLING PROVIDER INFO & PH #: (653) 3543248 Lemonapp Blvd, Raleigh, NC 35165

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

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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): 316 354 Y32

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 28 69 SEX M (X) F ( )

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

5. PATIENT'S ADDRESS (No., Street): 1920 ImRich lane

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): 1920 ImRich lane

CITY: Hollywood STATE: CA

8. RESERVED FOR NUCC USE

CITY: Hollywood STATE: CA

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

ZIP CODE: 89575 | TELEPHONE (Include Area Code): (888) 5712597

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: thd hku77

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 07 28 69 SEX M (X) F ( )

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES ( ) NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME: IronMan Health

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Tony Stark DATE 7/28/09

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

SIGNED Tony Stark

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 01 2013 QUAL: bad

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 07 05 2014 TO 05 08 2025

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Vision Red Man

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 04 12 2007 TO 04 12 2030

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ( ) NO (X) $ CHARGES: 000

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

A. E00-E90 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 09 12 00 09 25 00		FR	11	99213	21		120 87			NPI	1295319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: tL66 Ku8

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

28. TOTAL CHARGE: $ 55 87

29. AMOUNT PAID: $ 2 23

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 MD DATE

32. SERVICE FACILITY LOCATION INFORMATION: 55547 Lurry Lane Tegan, NY 55555

a. 1932 b. 356 123 00

33. BILLING PROVIDER INFO & PH #: (653) 354 3248 Lemonpop Blvd Raleigh, NC 35165

a. 000003 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

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 85247822T4

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

3. PATIENT'S BIRTH DATE: MM 08 DD 25 YY 97 — SEX: M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 807 Wisconsin Street

CITY: LeClaire — STATE: IA

ZIP CODE: 52753 — TELEPHONE (Include Area Code): (563) 2895066

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

7. INSURED'S ADDRESS (No., Street): 807 Wisconsin Street

CITY: LeClaire — STATE: IA

ZIP CODE: 52753 — TELEPHONE (Include Area Code): (563) 2895066

8. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

b. AUTO ACCIDENT? ☐ YES ☒ NO — PLACE (State):

c. OTHER ACCIDENT? ☒ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: G45Y77

a. INSURED'S DATE OF BIRTH: MM 08 DD 25 YY 97 — SEX: M ☐ F ☒

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem

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: Jennifer Wertz — DATE: 8/21/19

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: Jennifer Wertz

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 6 DD 03 YY 19 — QUAL. Good

15. OTHER DATE: QUAL. — MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 04 15 19 TO 12 12 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Kevin Daniels — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 04 15 19 TO 04 20 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? ☐ YES ☒ NO — $ CHARGES: 0.00

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

A. E00-E90 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24.

	A. From MM	DD	YY	To MM	DD	YY	B. Place of Service	C. EMG	D. CPT/HCPCS	Modifier				E. Diagnosis Pointer	F. $ Charges	G. Days or Units	H. EPSDT Family Plan	I. ID Qual.	J. Rendering Provider ID. #
1	12	5	99	02	08	00	11	55	99213	21					75.00			NPI	1245319599
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER (SSN EIN): 883-67-9700

26. PATIENT'S ACCOUNT NO.: 5348560988

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 566.92

29. AMOUNT PAID: $ 7.24

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 [illegible] DATE [illegible]

32. SERVICE FACILITY LOCATION INFORMATION
827 Jefferson Ct
Davenport, IA 52802
a. [illegible] b. [illegible]

33. BILLING PROVIDER INFO & PH # (563) 5988745
20202 Washington Rd
Bettendorf, IA 52722
a. [illegible] b.

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): 852478227T4

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

3. PATIENT'S BIRTH DATE: 08 25 97 | SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 807 WisconSiN Street

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

7. INSURED'S ADDRESS (No., Street): 807 WisconSiN Street

CITY: LeClaire | STATE: IA

8. RESERVED FOR NUCC USE

CITY: LeClaire | STATE: IA

ZIP CODE: 52753 | TELEPHONE (Include Area Code): (563 2895066

ZIP CODE: 52753 | TELEPHONE (Include Area Code): (563) 2895066

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: G45477

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 08 25 97 | SEX: 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? [X] YES [ ] NO

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 [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: JeNNifer Wertz | DATE: 8/21/19

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: Jennifer Wertz

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 6 03 19 | QUAL: Good

15. OTHER DATE: QUAL: | MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 04 15 19 TO 12 12 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. KeviN DaNiels

17a:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 04 15 19 TO 04 20 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? [ ] YES [X] NO | $ CHARGES: 0 00

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

A. E00-E90 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: | ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL	J RENDERING PROVIDER ID. #
1	12 5 99	02 08 00	11	55	99213	21			75.09		NPI	1245319599
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 883-67-9700 | SSN EIN

26. PATIENT'S ACCOUNT NO.: 5348560988

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

28. TOTAL CHARGE: $ 566.92

29. AMOUNT PAID: $ 7.24

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: 827 Jefferson Ct Davenport, IA 52802

a. NPI b.

33. BILLING PROVIDER INFO & PH#: (563 5988745 20202 Washington Rd Bettendorf, IA 52722

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): 852478227T4

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 25 97 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 807 Wisconsin Street

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

7. INSURED'S ADDRESS (No., Street): 807 Wisconsin Street

CITY: LeClaire STATE: IA

8. RESERVED FOR NUCC USE

CITY: Le Claire STATE: IA

ZIP CODE: 52753 TELEPHONE (Include Area Code): (563) 2895066

ZIP CODE: 52753 TELEPHONE (Include Area Code): (563) 289 5066

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: G45Y77

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: 08 25 97 SEX 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? [X] YES [ ] NO

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 [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: Jennifer Wertz DATE: 8/21/19

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: Jennifer Wertz

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 6 03 19 QUAL: Good

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 04 15 19 TO 12 12 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Keum Daniels

17a:

17b NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 04 15 19 TO 04 20 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 0 00

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

A. E00-E90 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 12 5 99	02 08 00	11	55	99213	21		75 00			NPI	1245319599
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 883-67-9700

26. PATIENT'S ACCOUNT NO.: 5348560988

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

28. TOTAL CHARGE: $ 566.92

29. AMOUNT PAID: $ 7.24

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 MDH DATE: 8

32. SERVICE FACILITY LOCATION INFORMATION: 827 Jefferson Ct Davenport, IA 52802

a NPI

b

33. BILLING PROVIDER INFO & PH # (563) 5988745: 20202 Washington Rd Bettendorf, IA 52722

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): 241370DB3

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 [X] 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 [X] 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) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH: MM 3 DD 9 YY 86 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:

d. INSURANCE PLAN NAME OR PROGRAM NAME: Anthem

10d. CLAIM CODES (Designated by NUCC): IC3

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 _____ DATE 09/27/2019

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 _____

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 [X] 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

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	6	3	19	6	10	19	CD				14572 13	7		NPI	432ABCX
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

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

26. PATIENT'S ACCOUNT NO.: 99937654

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

28. TOTAL CHARGE: $ 14572 13

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

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

SIGNED 9/10/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b

33. BILLING PROVIDER INFO & PH # ( )

a NPI b

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72

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

3. PATIENT'S BIRTH DATE: MM 10 DD 30 YY 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: MM 10 DD 30 YY 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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 9 DD 1 YY 2019 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. 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		93410		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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE [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: MM 06 DD 31 YY 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: 63011 | 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: MM 08 DD 17 YY 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

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 08 DD 31 YY 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 10 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 2014 TO 09 02 2014

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	14	09	02	14	Mer				10000.00	3		NPI	12487612
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 8746794 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12468109

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

28. TOTAL CHARGE: $ 10000.00

29. AMOUNT PAID: $ 800.00

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 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

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): 12345DBA

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

3. PATIENT'S BIRTH DATE: 08 | 43 | 00 SEX: M [X] F [ ]

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

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

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

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

CITY: St Louis STATE: M

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: 15213212

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

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

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

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 04 | 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: FROM 04 | 10 | 2012 TO 10 | 12 | 2014

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Nothing

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 42000.00

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

A. sick B. congestion C. sinuses D.
E. fever F. flu G. heart H.
I. illness J. cold K. Diabetes L.

22. RESUBMISSION CODE: 52110 ORIGINAL REF. NO.: 52001

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	0 8 19	09 19 19		X										NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

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

26. PATIENT'S ACCOUNT NO: 11111111

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

28. TOTAL CHARGE: $ 5000.15

29. AMOUNT PAID: $ 25000.15

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION: SLCC

a. NPI b.

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

a. GRP b.

NUCC Instruction Manual available at www.nucc.org

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