PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

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PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 11-2234-10190

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

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

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

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

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

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

CITY: Any City STATE: CA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Any City STATE: CA

ZIP CODE: 92127 TELEPHONE (Include Area Code): (858) 555-0100

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 92127 TELEPHONE (INCLUDE AREA CODE): (858) 555-0100

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: G4683A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 06 12 65 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Group Insur of Amer.

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

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: JDoe DATE: 01-15-2021

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: JaneDoe

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 10 11 21 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 11 21

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Self

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. R11.0
2. K59.00
3. R19.7
4. K92.1

22. MEDICAID 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 11 21		11		90801			170 00					1234567890
2 10 11 21		11		90805			140 00					1234567890
3 10 11 21		11		90812			93 00					1234567890
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555-88-9999 [X]

26. PATIENT'S ACCOUNT NO.:

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

28. TOTAL CHARGE: $ 405 .00

29. AMOUNT PAID: $

30. BALANCE DUE: $

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: MtJackson DATE: 10/11/21

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Mateo Jackson PhD
9876 Healthcare Ave
Any Town, CA 92126

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Mateo Jackson PhD
9876 Healthcare Ave (920) 555-0101
Any Town, CA 92126

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500