

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05										ORTHOGROUP PO BOX 2311 ALPHARATTA, GA 30023									
PICA										PICA									
1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA BLK OTHER CHAMPUS HEALTH PLAN LUNG (Medicare #) (Medicaid #) (Sponsor SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a INSURED I.D. NUMBER (For Program in item 1)									
2. PATIENT NAME (Last Name, First Name, Middle Initial) deepa										3PATIENT BIRTH DATE SEX MM DD YY M F 10 15 1999									
2. PATIENT ADDRESS (No., Street) Chandigarh SCO no. 108-109										4. INSURED NAME (Last Name, First Name, Middle Initial)									
CITY STATE Chandigarh Georgia										7. INSURED ADDRESS (No., Street) CITY State									
ZIP CODE TELEPHONE (Include Area Code) 123456 (1234567890)										6PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 8 PATIENT STATUS Single Married Other									
9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT CONDITION RELATED TO: Employed Full-Time Part-Time Student Student									
a. OTHER INSUREDS POLICY OR GROUP NUMBER										11. INSURED POLICY GROUP OR FECA NUMBER									
bOTHER INSURED DATE OF BIRTH SEX MM DD YY M F										aEMPLOYMENT ? (Current or Previous) YES NO									
cEMPLOYERS NAME OR SCHOOL NAME										bAUTO ACCIDENT YES NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										cINSURANCE PLAN NAME OR PROGRAM NAME SELF									
12PATIENTS OR AUTHORIZES PERSONS 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										bINSURED OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below SIGNED									
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS FIVE FIRST DATE MM DD YY									
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. NORMAN V LEWIS MD										16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3, or 4 item 24E by line) 1. 20550 3. 20605 2. 20550										20 OUTSIDE LAB ? \$ CHARGES YES NO									
22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO. 23 PRIOR AUTHORIZATION NUMBER																			
24 DATE(S) OF SERVICES B. PLACE OF SERVICE C. EMG D. PROCEDURES SERVICES OR SUPPLIES (Explain Unusal Circumstances) E. DIA GNOSIS F. \$ CHARGES G. DAYS EPSDIT OR U FAMILY NITS H. PLAM I ID QUAL J RENDERING PROVIDER ID. #																			
										AB \$ NPL 567A									
										AB \$ NPL 567A									
										AB \$29,999.00 NPL 567A									
25. FEDERAL TAX. I.D. NUMBER SSN EIN 776188										26. PATIENT ACCOOUNT NO. 27. ACCEPT ASSIGNMENT YES NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DRGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										29. TOTAL CHARGES \$29,999.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$29,999.00									
32. SERVICE FACILITY LOCATION INFORMATION Chandigarh SCO no. 108-109 Georgia Chandigarh, 123456 Mob. No.1234567890 Office. No.1234567890 1407965015 DR. Doctor Smith										BILLING PROVIDER INFO & 866 411-2525 PH # ORTHOGROUP P O BOX 2311 ALPHRETTA, GA 30023 a. b.									