

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) Bill Gertson												3 PATIENT BIRTH DATE SEX MM DD YY M F 04 12 1968											
2. PATIENT ADDRESS (No., Street)												6 PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other											
CITY STATE												8 PATIENT STATUS Single Married Other											
ZIP CODE TELEPHONE (Include Area Code) 0 ()												Employed Full-Time Part-Time Student Student											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT CONDITION RELATED TO:											
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a EMPLOYMENT ? (Current or Previous) YES NO											
b OTHER INSURED DATE OF BIRTH SEX MM DD YY M F												b AUTO ACCIDENT YES NO											
c EMPLOYER'S NAME OR SCHOOL NAME												c OTHER ACCIDENT YES NO											
d. INSURANCE PLAN NAME OR PROGRAM NAME												d RESERVED FOR LOCAL USE											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM												11. INSURED POLICY GROUP OR FECA NUMBER											
12 PATIENTS 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												a INSURED DATE OF BIRTH SEX MM DD YY M F											
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY												b EMPLOYER'S NAME OR SCHOOL NAME SEX NAME MM DD YY M F											
15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS FIVE FIRST DATE MM DD YY												c INSURANCE PLAN NAME OR PROGRAM NAME SELF											
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. NORMAN V LEWIS MD												d IS THERE ANOTHER HEALTH BENEFIT PLAN ? YES NO If yes, return to & complete item 9 a-d											
19. RESERVED FOR LOCAL USE												b INSURED OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below SIGNED											
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3, or 4 item 24E by line) 1. 122345 3. 73600 2. 99214												16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
25. FEDERAL TAX. I.D. NUMBER SSN EIN 776188												18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DRG REES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE												20 OUTSIDE LAB ? \$ CHARGES YES NO											
32. SERVICE FACILITY LOCATION INFORMATION Mob. No. 1407965015 Office. No. DR. John Gaston												22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO. 23 PRIOR AUTHORIZATION NUMBER											
2. 4												29. TOTAL CHARGES \$2,500.00											
29. AMOUNT PAID \$0.00												30. BALANCE DUE \$2,500.00											
33. BILLING PROVIDER INFO & PH # ORTHOGROUP P O BOX 2311 ALPHARATTA, GA 30023												866 411-2525											