

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												3 PATIENT 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)												6 PATIENT 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											
b. OTHER INSURED DATE OF BIRTH SEX MM DD YY M F												a EMPLOYMENT ? (Current or Previous) YES NO b AUTO ACCIDENT YES NO											
c EMPLOYERS NAME OR SCHOOL NAME												b EMPLOYERS NAME OR SCHOOL NAME SEX NAME MM DD YY M F											
d. INSURANCE PLAN NAME OR PROGRAM NAME												c INSURANCE PLAN NAME OR PROGRAM NAME SELF											
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												d IS THERE ANOTHER HEALTH BENEFIT PLAN ? YES NO If yes, return to & complete item 9 a-d											
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY												b INSURED OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below SIGNED											
15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS FIVE FIRST DATE MM DD YY												16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. NORMAN V LEWIS MD												18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. RESERVED FOR LOCAL USE												20 OUTSIDE LAB ? \$ CHARGES YES NO											
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3, or 4 item 24E by line) 1. 1718.31 3. 1726.91 2. 1718.81 4. 1338.18												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. # FORM TO MM DD YY MM DD YY CPT/HCPCS MODIFIER																							
12 31 69 12 12 12												LT AB 1 NPL 567A											
12 31 69 12 12 12												LT AB 1 NPL 567A											
12 31 69 12 12 12												LT AB 1 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 \$6,000.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$6,000.00											
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.											