

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ORTHOGROUP
PO BOX 2311
ALPHARATTA, GA 30023

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1 MEDICARE MEDICAID TRICARE
CHAMPUS CHAMPVA GROUP
HEALTH
PLAN
(Medicare #) (Medicaid #) (Sponsor SSN) (Member ID#) (SSN or ID) (SSN) (ID)

2. PATIENT NAME (Last Name, First Name, Middle Initial)
deepa

2. PATIENT ADDRESS (No., Street)
Chandigarh SCO no. 108-109

CITY
Chandigarh

STATE
Georgia

ZIP CODE
123456

TELEPHONE (Include Area Code)
(1234567890)

3PATIENT BIRTH DATE
MM DD YY M F
10 15 1999

6PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

8 PATIENT STATUS
Single Married Other

Employed Full-Time Part-Time
Student Student

10. IS PATIENT CONDITION RELATED TO:
a EMPLOYMENT ? (Current or Previous)
YES NO

b AUTO ACCIDENT
YES NO

c OTHER ACCIDENT
YES NO

d RESERVED FOR LOCAL USE

4a INSURED I.D. NUMBER
(For Program in item 1)

4. INSURED NAME (Last Name, First Name, Middle Initial)

7. INSURED ADDRESS (No., Street)
CITY State

ZIP CODE TELEPHONE (Include Area Code)
40203 ()

11. INSURED POLICY GROUP OR FECA NUMBER
a INSURED DATE OF BIRTH SEX
MM DD YY M F

b EMPLOYERS NAME OR SCHOOL SEX
NAME MM DD YY M F

c INSURANCE PLAN NAME OR PROGRAM NAME
SELF

d IS THERE ANOTHER HEALTH BENEFIT PLAN ?
YES NO If yes, return to & complete item 9 a-d

9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)
a. OTHER INSUREDS POLICY OR GROUP NUMBER

b OTHER INSURED DATE OF BIRTH SEX
MM DD YY M F

c EMPLOYERS NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

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

17a. 1 G
17b. NPL

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

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. 20550 3. 20605
2. 20550

22 MEDICAID RESUBMISSION
CODE ORIGINAL REF NO.
23 PRIOR AUTHORIZATION NUMBER

2 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

02 20 15 02 12 15 LT AB 0 1 NPL

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02 20 15 02 12 15 LT AB 0 1 NPL

25. FEDERAL TAX. I.D. NUMBER SSN EIN
776188

26. PATIENT ACCOOUNT NO. 27. ACCEPT ASSIGNMENT
YES NO

29. TOTAL CHARGES \$0.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$0.00

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

32. SERVICE FACILITY LOCATION INFORMATION
Chandigarh SCO no.
108-109 Georgia Chandigarh, 123456
Mob. No.1234567890
Office. No.1234567890
1407965015 DR. Mark Adamson

BILLING PROVIDER INFO & 866 411-2525
PH #
ORTHOGROUP P O BOX 2311 ALPHRETTA, GA 30023
a. b.

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