

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 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)									
6 PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED ADDRESS (No., Street)									
CITY STATE Chandigarh Georgia										8 PATIENT STATUS Single Married Other									
ZIP CODE TELEPHONE (Include Area Code) 123456 (1234567890)										CITY STATE State									
9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT CONDITION RELATED TO: Employed Full-Time Student Part-Time Student									
11. INSURED POLICY GROUP OR FECA NUMBER										11. INSURED DATE OF BIRTH SEX MM DD YY M F									
a. OTHER INSUREDS 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 EMPLOYERS NAME OR SCHOOL NAME										c OTHER ACCIDENT YES NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d RESERVED FOR LOCAL USE									
d IS THERE ANOTHER HEALTH BENEFIT PLAN ? YES NO If yes, return to & complete item 9 a-d										b INSURED OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below SIGNED									
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										16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
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										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									
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																			
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 ACCOOOUNT NO. 27. ACCEPT ASSIGNMENT YES NO									
29. TOTAL CHARGES \$17446.00										29. AMOUNT PAID \$0.00									
30. BALANCE DUE \$17446.00																			
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. Doctor Smith									
BILLING PROVIDER INFO & PH # ORTHOGROUP P O BOX 2311 ALPHRETTA, GA 30023										866 411-2525 a. b.									