1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ORTHOGROUP
PO BOX 2311
ALPHARATTA, GA 30023

PICA

1 MEDICARE | MEDICAID | TRICARE CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

(Medicare #) *(Mediciaid #)* *(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)
Jeff Rimmel

3 PATIENT BIRTH DATE SEX
MM DD YY M F
06 06 1985

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

2. PATIENT ADDRESS (No., Street)
123 Main Street

6 PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED ADDRESS (No., Street)

CITY
Atlanta

STATE
Georgia

8 PATIENT STATUS
Single Married Other

CITY

State

ZIP CODE
30152

TELEPHONE (Include Area Code)
(2147483647)

Employed Full-Time Student Part-Time Student

ZIP CODE
40203

TELEPHONE (Include Area Code)
( )

9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT CONDITION RELATED TO:

11. INSURED POLICY GROUP OR FECA NUMBER

a. OTHER INSUREDS POLICY OR GROUP NUMBER

a EMPLOYEMENT ? (Current or Previous)
YES NO

a INSURED DATE OF BIRTH SEX
MM DD YY M F

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

b AUTO ACCIDENT
YES NO

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

c EMPLOYERS NAME OR SCHOOL NAME

c OTHER ACCIDENT
YES NO

c INSURANCE PLAN NAME OR PROGRAM NAME
SELF

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 & compelete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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 _____

b INSURED OR AUTHORIZED PERSONS SIGNATURE I authroize payment of medical benefits to the unsdersigned 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

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 C73647
17b. NPL 1407965015

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
2. 1718.81
3. 1726.91
4. 1338.18

22 MEDICAID RESUBMISSION
CODE ORIGINAL REF NO.

23 PRIOR AUTHORIZATION NUMBER

24 DATE(S) OF SERVICES FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES SERVICES OR SUPPLIES (Explain Unusal Circumstance) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDIT FAMILY PLAM	I ID QUAL	J RENDERING PROVIDER ID. #
01	16	15	10	30	14				LT	AB	6,000	1		NPL	
02	09	15	10	30	14				LT	AB	0	1		NPL	
02	09	15	10	30	14				LT	AB	7,000	1		NPL	

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

26. PATIENT ACCOUNT NO.
776188

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 SUPPILER INCLUDING DRGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part there of.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LOUISVILLE ORTHOPAEDIC CLINIC 4130 DUTCHMANS LN-STE 104 LOUISVILLE, KY 40207-4713
1407965015 DR. NORMAN LEWIS

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