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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (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										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other									
CITY STATE Chandigarh Georgia										8. PATIENT STATUS Single Married Other									
ZIP CODE TELEPHONE (Include Area Code) 123456 (1234567890)										7. INSURED ADDRESS (No., Street) ZIP CODE TELEPHONE (Include Area Code) 40203 ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT CONDITION RELATED TO: a. EMPLOYMENT ? (Current or Previous) YES NO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED DATE OF BIRTH SEX MM DD YY M F									
b. OTHER INSURED DATE OF BIRTH SEX MM DD YY M F										b. EMPLOYERS NAME OR SCHOOL SEX NAME MM DD YY M F									
c. EMPLOYERS NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME SELF									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN ? YES NO If yes, return to & complete item 9 a-d									
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 authorize payment of medical benefits to the undersigned 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									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. NORMAN V LEWIS MD										17a. 1 G C73647 17b. NPL 1407965015									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
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										20. OUTSIDE LAB ? \$ CHARGES YES NO									
2. DATE(S) OF SERVICES B. PLACE OF SERVICE C. EMG D. PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINT F. \$ CHARGES G. DAYS OR FAMILY NITS H. EPSDT OR 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										22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO. 23. PRIOR AUTHORIZATION NUMBER									
25. FEDERAL TAX. I.D. NUMBER SSN EIN 776188										26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT YES NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DR. GREGG'S 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 29. AMOUNT PAID 30. BALANCE DUE \$17446 00 \$0.00 \$17446 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.									