

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  
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)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED DATE OF BIRTH    SEX

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

3 PATIENT BIRTH DATE    SEX

MM   DD   YY   M   F

10   15   1999

6 PATIENT 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

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. EMPLOYER'S NAME OR SCHOOL NAME    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

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

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

4 FORM    TO

MM   DD   YY   MM   DD   YY

B. PLACE OF SERVICE

C. EMG

D. PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER

E. DIA GNOSIS POIN TER

F. \$ CHARGES

G. DAYS EPSDIT OR U FAMILY NITS

H. PLAM

I ID QUAL

J RENDERING PROVIDER ID. #

12   31   69   12   31   69

12   31   69   12   31   69

12   31   69   12   31   69

LT

LT

LT

AB

\$

\$34,067.99

NPL

567A

25. FEDERAL TAX. I.D. NUMBER

SSN EIN

776188

26. PATIENT ACCOOUNT NO.

27. ACCEPT ASSIGNMENT

YES   NO

29. TOTAL CHARGES

\$34,067.99

29. AMOUNT PAID

\$0.00

30. BALANCE DUE

\$34,067.99

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

a.

b.

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