

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ORTHOGROUP
PO BOX 2311
ALPHARATTA, GA 30023

PICA

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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)

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 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 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 Unusual Circumstances) CPT/HCPCS E. DIA GNOSIS F. \$ CHARGES G. DAYS EPSDT 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

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12 31 69 12 12 12

20550 LT

20550 LT

20605 LT

AB

AB

AB

1

1

1

NPL

NPL

NPL

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

776188

26. PATIENT ACCOOUNT 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. Mark Adamson

BILLING PROVIDER INFO & PH #

866 411-2525

ORTHOGROUP P O BOX 2311 ALPHRETTA, GA 30023

a.

b.

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