

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05												ORTHOGROUP PO BOX 2311 ALPHARATTA, GA 30023																																																																																															
PICA												PICA																																																																																															
1 MEDICARE  (Medicare #) <input type="checkbox"/>												MEDICAID  (Medicaid #) <input type="checkbox"/>												TRICARE CHAMPUS  (Sponsor SSN) <input type="checkbox"/>												CHAMPVA  (Member ID#) <input type="checkbox"/>												GROUP HEALTH PLAN  (SSN or ID) <input type="checkbox"/>												FECA BLK LUNG  (SSN) <input type="checkbox"/>												OTHER  (ID) <input type="checkbox"/>												1a INSURED I.D. NUMBER  (For Program in item 1)																							
2. PATIENT NAME (Last Name, First Name, Middle Initial) deepa												3PATIENT BIRTH DATE MM DD YY M <input type="text"/> F <input type="text"/> 10 15 1999												SEX												4. INSURED NAME (Last Name, First Name, Middle Initial)																																																																							
2. PATIENT ADDRESS (No., Street) Chandigarh SCO no. 108-109												6PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED ADDRESS (No., Street)																																																																																			
CITY Chandigarh												STATE Georgia												8 PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>												CITY State																																																																							
ZIP CODE 123456												TELEPHONE (Include Area Code) (1234567890)												Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>												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 EMPLOYMENT ? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>												aINSURED DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																			
bOTHER INSURED DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>												bAUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>												bEMPLOYERS NAME OR SCHOOL NAME MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																			
cEMPLOYERS NAME OR SCHOOL NAME												c OTHER ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>												cINSURANCE PLAN NAME OR PROGRAM NAME SELF																																																																																			
d. INSURANCE PLAN NAME OR PROGRAM NAME												dRESERVED FOR LOCAL USE												dis THERE ANOTHER HEALTH BENEFIT PLAN ? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to & complete item 9 a-d																																																																																			
12PATIENTS 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												15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS FIVE FIRST DATE Date MM DD YY												bINSURED 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												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																																																																																			
19. RESERVED FOR LOCAL USE												20 OUTSIDE LAB ? <input type="checkbox"/> YES <input type="checkbox"/> NO												\$ CHARGES																																																																																			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3, or 4 item 24E by line) 1. 20550 2. 20550 3. 20605												22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO. 23 PRIOR AUTHORIZATION NUMBER																																																																																															
2 DATE(S) OF SERVICES FORM TO MM DD YY MM DD YY												B. PLACE OF SERVICE												C. EMG												D. PROCEDURES SERVICES OR SUPPLIES (Explain Unusal Circumstances) CPT/HCPCS MODIFIER												E. DIA GNOSIS POIN TER												F. \$ CHARGES												G. DAYS EPSDIT OR U FAMILY PLAM												H. ID QUAL												J RENDERING PROVIDER ID. #											
02 20 15 02 12 15																																				LT												AB												1,000												1												NPL												567A											
02 20 15 02 12 15																																				LT												AB												1,000												1												NPL												567A											
02 20 15 02 12 15																																				LT												AB												4,000												1												NPL												567A											
25. FEDERAL TAX. I.D. NUMBER												SSN EIN 776188												26. PATIENT ACCOOUNT NO.												27. ACCEPT ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO												29. TOTAL CHARGES \$6,000.00												29. AMOUNT PAID \$0.00												30. BALANCE DUE \$6,000.00																																			
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												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.												866 411-2525 b.																																																											