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)
Testing Test

3 PATIENT BIRTH DATE SEX
MM DD YY M F
09 11 2014

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

2. PATIENT ADDRESS (No., Street)
#555666

6 PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED ADDRESS (No., Street)

CITY
sdfdsfdsfsdf

STATE
Illinois

8 PATIENT STATUS
Single Married Other

CITY

State

ZIP CODE
12121

TELEPHONE (Include Area Code)
(1234567890)

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.
17b.
1 G
NPL

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)

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 Unusual Circumstance) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAM	I ID QUAL	J RENDERING PROVIDER ID. #

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

26. PATIENT ACCOUNT NO.
776188

27. ACCEPT ASSIGNMENT
YES NO

29. TOTAL CHARGES	29. AMOUNT PAID	30. BALANCE DUE
$29,999.00	$0.00	$29,999.00

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
#555666 Illinois sdfdsfdsfsdf, 12121
Mob. No.1234567890
Office. No.123456
1407965015 DR. Doctor Smith

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