

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 CHAMPVA GROUP FECA BLK OTHER HEALTH PLAN LUNG (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) Hoe Shelby										3PATIENT BIRTH DATE SEX MM DD YY M F 03 28 1745									
2. PATIENT ADDRESS (No., Street)										6PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other									
CITY STATE										8 PATIENT STATUS Single Married Other									
ZIP CODE TELEPHONE (Include Area Code) 0 ( )										Employed Full-Time Part-Time Student Student									
9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT CONDITION RELATED TO:									
a. OTHER INSUREDS POLICY OR GROUP NUMBER										a EMPLOYMENT ? (Current or Previous) YES NO									
bOTHER INSURED DATE OF BIRTH SEX MM DD YY M F										bAUTO ACCIDENT YES NO									
cEMPLOYERS NAME OR SCHOOL NAME										c OTHER ACCIDENT YES NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										dRESERVED FOR LOCAL USE									
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										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										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										16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
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. 99213										20 OUTSIDE LAB ? \$ CHARGES YES NO									
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 Unusal Circumstances) E. DIA GNOSIS F. \$ CHARGES G. DAYS EPSDIT H. OR U FAMILY I ID QUAL J RENDERING PROVIDER ID. # FORM TO MM DD YY MM DD YY CPT/HCPCS MODIFIER										24 03 12 15 03 09 15 99213 LT AB 800 1 NPL									
25. FEDERAL TAX. I.D. NUMBER SSN EIN										26. PATIENT ACCOOUNT NO. 27. ACCEPT ASSIGNMENT 776188 YES NO									
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										29. TOTAL CHARGES \$800.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$800.00									
32. SERVICE FACILITY LOCATION INFORMATION , 0 Mob. No. Office. No. 1407965015 DR. Dr James Clement										BILLING PROVIDER INFO & 866 411-2525 PH # ORTHOGROUP P O BOX 2311 ALPHRETTA, GA 30023 a. b.									