HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Tristar Risk Management
Submitted Electronically via Jopari
(Payer ID: 41556)

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoD#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLACKLUNG ☐ (ID#)	OTHER ☐ (ID#)

1.a INSURED'S I.D. NUMBER (For Program in item 1): 556-46-4521

2. PATIENT'S NAME(Last Name, First Name, Middle Initial): ANKIT GUPTA

3. PATIENT'S BIRTH DATE: MM 03 | DD 30 | YY 95 — SEX: M ☐ F ☐

4. INSURED'S NAME(Last Name, First Name, Middle Initial): ANKIT GUPTA

5. PATIENT'S ADDRESS (NO.,Street): RAJENDRA NAGAR

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (NO.,Street): RAJENDRA NAGAR

CITY: Anatone | STATE: WA

8. RESERVED FOR NUCC USE: Value

CITY: Anatone | STATE: WA

ZIPCODE: 99401 | TELEPHONE(Include Area Code): (996) 865-4856

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

10. IS PATIENT'S CONDITION RELATED TO:: Value

11. INSURED'S POLICY GROUP OR FECA NUMBER: Value

ZIPCODE: 99401 | TELEPHONE(Include Area Code): (996) 865-4856

a. OTHER INSURED'S POLICY OR GROUP NUMBER: Value

a. EMPLOYMENT?(Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH: MM 03 | DD 30 | YY 95 — SEX: M ☐ F ☐

b. RESERVED FOR NUCC USE: Value

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 994218WC981 | Value

c. RESERVED FOR NUCC USE: Value

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Value

d. INSURANCE PLAN NAME OR PROGRAM NAME: Value

10d. CLAIM CODES (Designated by NUCC): Value

d. IS THERE ANOTHER HEALTH BENIFIT PLAN? ☐ Yes ☐ No **If yes,** complete items 9,9a, and 9d.

READ BACK OF FORM BEFORE COMPLETEING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benifits either to myself or to government benifits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 10/10/2023

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benifits to the undersigned physician or supplier for service described below.

SIGNED: _____

PHYSICIAN OR SUPPLIER INFORMATION

14.DATE OF CURRENT ILLNESS, INJURY,or PREGNANCY (LMP): MM Value | DD Value | YY Value | QUAL. Value

15. OTHER DATE: QUAL. Value | MM Value | DD Value | YY Value

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM 00 DD 00 YY 00 TO MM 00 DD 00 YY 00

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17.a value

17.b NPI value

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM 00 DD 00 YY 00 TO MM 00 DD 00 YY 00

19.ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Value

20. OUTSIDE LAB? ☐ Yes ☐ No — $CHARGES: Value | Value

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) — ICD Ind. Value | Value

A. Value B. Value C. Value D. Value

E. Value F. Value G. Value H. Value

I. Value J. Value K. Value L. Value

22. RESUBMISSION CODE: Value | ORIGINAL REF. NO.: Value

23. PRIOR AUTHORIZATION NUMBER: Value

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	**B.** PLACE OF SERVICE	**C.** AMG	**D.** PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	**E.** DIAGNOSIS POINTER	**F.** $ CHARGES	**G.** DAYS OR UNITS	**H.** EPSDT Family Plan	**I.** ID QUAL.	**J.** RENDERING PROVIDER ID.#
1	01 01 18	01 01 18	value 01	value value				00 00	00	00	NPI	1215628623
2	00 00 00	00 00 00	value value	value value	00	00 00 00 00		00 00	00	00	NPI	1215628623
3	00 00 00	00 00 00	value value	value value	00	00 00 00 00		00 00	00	00	NPI	1215628623
4	00 00 00	00 00 00	value value	value value	00	00 00 00 00		00 00	00	00	NPI	1215628623
5	00 00 00	00 00 00	value value	value value	00	00 00 00 00		00 00	00	00	NPI	1215628623
6	00 00 00	00 00 00	value value	value value	00	00 00 00 00		00 00	00	00	NPI	1215628623
	00 00 00	00 00 00	value value	value value	00	00 00 00 00		00 00	00	00	NPI	1215628623

25. FEDERAL TAX I.D NUMBER SSN ☐ EIN ☐: 38-4144036

26. PATIENT'S ACCOUNT NO.: 477db9122800-1

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ 0.00.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC Use: - 0.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Angel Mancheno

SIGNATURE ON FILE — SIGNED — 10/10/2023 — DATE

32. SERVICE FACILITY LOCATION INFORMATION

City of Industry
City of Industry
City of Industry
City of Industry California

a. 28-4144036 b.

33. BILLING PROVIDER INFO & PH # ( )

Halo Services Inc
P.O. Box 1968
Montebello California 90640

a. 28-4144036 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 form 1500 (02-12)