Sedgwick Claims Management Services
Submitted Electronically via Data Dimensions
(Payer ID: CB280)

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program i
	Dummy S S no
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Dummy Patient Name	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 2023 SEX M X F
5. PATIENT'S ADDRESS (No., Street): Patient Address	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other X
CITY: Patient City / STATE: Patient State	8. RESERVED FOR NUCC USE
ZIP CODE: Patient Zipcode / TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? X YES NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? X YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC) X

1c. INSURED'S ADDRESS (No., Street)	
CITY	S
ZIP CODE	TELEPHONE (Include Area C ( )
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY / SEX M	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME: Y4 Claim No	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, an	

READ BACK OF FORM BEFORE COMPLETING & 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 benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I au payment of medical benefits to the undersigned physician or s services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. 11/11/2022 MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP MM DD YY FROM MM DD YY TO
SIGNATURE ON FILE		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Injury Month Injury Date 2023	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERV MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. B. C. D. 0		23. PRIOR AUTHORIZATION NUMBER
Bill Diagnosis Code Numbers E. F. G. H.		
I. J. K. L.		

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	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. RENDE NPI
1 03 20 2023 03 20 2023			Long Beach Bill Procedure Code	Modifier		Bill Amount	Bill Units		ZZ	1063480192
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Tax Id	477db9122800-1	Total Charge
SIGNED DATE	a. Long Beach NPI b. Address Line1 Address Line2 California	a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

Billing Provider Name
Signature on File 12/06/2022