HEALTH INSURANCE CLAIM FORM

| APPROVED BY NATIONAL | . UNIFORM CLAIM CO | MMITTEE (NUCC) 02/12 |
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| HEALTH INSUR | | | | | | | | | | | | AN - | 1TRI | JST NO | ORTH AM | 1ERICA | | | | CARRIER |
|--|-------------------|---|------------------|----------------|-------------------|----------------------------|--------------------|---------------------|---|---------------|--------------------|---------------|--------------------|---|--------------------------------------|---------------------------|-----------|------------|--------------------------------|---------------------------------|
| PICA | | 2 00 | | 0, 02, 12 | | | | | | | | | | | CM | S1500 PA | AGE 1 OF | 8 PI | CA | ٦↓ |
| 1. MEDICARE MEDIC (Medicare#) | AID Medicaid# | TRICARE | : C #/DoD#) [| HAMPVA (Mer | A mber ID# | | UP HEA | LTH PL | AN FE | _ | LACKLUNG D#) | OTHER X (I | | 1.a INSU | RED'S I.D. NI D-0000 | UMBER | (Fo | or Pro | gram in item 1) | † |
| 2. PATIENT'S NAME(Last N | lame, First | Name, Mid | dle Initial) | | l | IENT'S BI | | 100 | YY | | EX M X | FΠ | | | | | | ame, l | Middle Initial) | $\exists 1$ |
| MILANA, CHRIS 5. PATIENT'S ADDRESS (N | O.,Street) | | | | | IM ! IENT REL | DD ATIONS | | | | M X | <u>г Ш</u> | | | (I RCM SO RED'S ADDR | | | | | $\exists 1$ |
| , ST. #208 8020 DE PA | LMA | | | | Self | | Spouse | | | ild | Oth | er X | | | | | | | | |
| CITY LAKEWOOD | | | STATE CA | | 8. RESI | ERVED F | OR NUC | CC USE | | | | | | CITY LOS AI | NGELES | | | | STATE CA | ATIO |
| ZIPCODE | | | de Area Cod | le) | | | | | | | | | | ZIPCOD | E | | TELEPHON | NE(In | clude Area Code) | FORM |
| 90713 9. OTHER INSURED'S NAM | | 9) 612-314! me, First Na | | nitial) | 10 . IS P | PATIENT'S | S COND | ITION | RELATE | D TO: | | | | 90017 11. INSU | RED'S POLIC | CY GROUP | OR FECA | NUM | IBER | — ≧ |
| a. OTHER INSURED'S POLI | CY OR GR | OUP NUMB | ER | | a. EMPI | LOYMEN | | | - |) | | | | a. INSUR Mi | ED'S DATE | OF BIRTH DD | . YY | | SEX M F | NSURE |
| b. RESERVED FOR NUCC U | JSE | | | | b. AUT0 | O ACCIDI | YES ENT? YES | _ |] NO] NO | PL | ACE (State) | | | | R CLAIM ID (15689-1 | Designated | d by NUCC | :) Valu | ıe | PATIENT AND INSURED INFORMATION |
| c. RESERVED FOR NUCC U | ISE | | | | c. OTHI | ER ACCIE | DENT? | | | | | | | | ANCE PLAN | NAME OF | R PROGRAM | M NAI | ME | ATIEN |
| d. INSURANCE PLAN NAM | E OR PRO | GRAM NAM | IE | | 10d . CL | AIM COE | YES DES (Des | | NO d by NUC | CC) | | | | | RE ANOTHE | | | | ems 9,9a, and 9d. | - d |
| 12. PATIENT'S OR AUTHOR claim. I also request paymer assignment below. | ZED PERS | ON'S SIGNA | | rize the r | release o | of any me rnment be | edical or o | other in ther to | nformatio myself o | | | | | 13. INSU payment for service | RED'S OR All of medical ce described | UTHORIZE benifits to | D PERSON | I'S SIC | GNATURE I authoriz | |
| SIGNED SIGNATU 14.DATE OF CURRENT ILLN | | | IANCY (I MD) | | 15 OTH | HER DATE | E 10 | /10/20 | J23 | | | | | | S DATIENT I | INIARI E TO |) WORK IN | CLID | DENIT OCCUPATION | |
| MM DD Value Value | | YY Value | QUAL. | ′ | QUAL. | | | MM Valu | | | DD : | YY Value | 2 | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM ! ! ! TO ! ! ! | | | | | | |
| 17. NAME OF REFERRING P | 17.a | | | | | | | , | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | |
| | | | | | | 17.b |) | | | NP | l | | | FROM ! ! ! TO ! ! ! 120. OUTSIDE LAB? \$CHARGES | | | | | | |
| 19. DATES PATIENT UNABL | E TO WOR | K IN CURRE | NT OCCUPA | TION | | | | | | | | | | Ye | | 100 | GES | | | 41 |
| 21. DIAGNOSIS OR NATURI | OF ILLNE | SS OR INJU | RY Relate A- | L to servi | ice line b | pelow(24 | E) | | | | ICD Ind. | 10 | | CODE | | RIGINAL RI | EF. NO. | | | |
| A. A009 E. Value | B | | | | _ | Value Value | | | _ D. H. | _ | ilue | | - | 23. PRIO | R AUTHORIZ | ZATION N | JMBER | | | 71 |
| I. Value | | | | | _ | Value | | | _ L. | _ | lue | | | | | | | | | _ N |
| 24. A. DATE(S) OF SERVICE From MM DD YY MM | То | B. PLACE OF SERVICE | J - | D. PROCE | (Explai | , SERVICE in Unusua | al Circum | 0 | es) | | E. DIAGNOS POINTER | | \$ CHA | RGES | G. DAYS OR UNITS | H. EPSDT Family Pla | | AL. I | J. RENDERING PROVII ID.# | - |
| | | | | 011/11 | 01 00 | | 710 | DITTER | | | | | | | | , | ZZ | 2 | 1215628623 | 틸 |
| 11 01 23 | | 11 | | 992 | 214 | | | | | | Α | | 392 | 58 | 1 | 004 | NPI | | 1144239401 | EB |
| | | | | | | | | | | | | | _ | | _ | | ZZ | | 1215628623 | 년 |
| 11 01 23 | | 11 | | WC | 002 | | <u>!</u> | ! | | 4 | | | 0 | 0 | 1 | 004 | NPI | | 1144239401 | s |
| 11 01 23 | - 1 | 11 | | 977 | 50 | ı | | | | | A ,B ,C , | D | 106 | 62 | 1 | 004 | ZZ | + | 1215628623 1144239401 | O |
| | | • | | 3 | | | ! | ! | | | 7,5,5,6, | , = | | | • | 001 | ZZ | | 1215628623 | |
| 11 01 23 | | 11 | | 971 | 24 | | | | | | A ,B ,C , | ,D | 95 | 62 | 1 | 004 | | + | 1144239401 | PHYSICIAN OR SUPPLIER INFORMA |
| | • | | | | | | | • | • | | | | | • | | | ZZ | | 1215628623 | |
| 11 01 23 | | 11 | | 978 | 310 | | | | | | A ,B ,C , | ,D | 117 | 86 | 1 | 004 | NPI | | 1144239401 | |
| 11 01 23 | - | 11 | | 978 | 311 | | 1 | 1 | - | | A ,B ,C , | .D | 87 | 86 | 1 | 004 | ZZ | + | 1215628623 1144239401 | |
| 25. FEDERAL TAX I.D NUME | ER | <u> </u> | SSN EIN | | | ACCOU | : NT NO. | - | 27. AC | L CEPT | ASSIGNMEN | | | | L CHARGE | 29. AMO | UNT PAID | - | Rsvd for NUCC Use | ə |
| 330184132 | | | | 477 | DB912 | 2800-1 | | | (For go | ovt. cl YE | aims, see bad S | ck) NO | | | 055 .3 | \$ | 00.00 | | o .00 | + |
| 31. SIGNATURE OF PHYSIC DEGRESS OR CREDENTIAL | S (I certify | that the sta | tements on | Fresr 2440 | no-Nev) W Sha | aw Ave | #106 | ON INFO | ORMATIC | ON | | | | 33. BILLIN WorkM PO BO | IG PROVIDE led Califor X 3327 | R INFO & I | PH #() | | | |
| the reverse apply to this bill Kevin Calhoun | and are m | | | | | aw Ave | | rnia | | | | | | Seal Be | ach Calif | ornia | | 907 | 40 | |
| SIGNATURE ON FILE | Fresno California | | | | | | | | | | | | a. N 1487029278 b. | | | | | | | |



HEALTH INSURANCE CLAIM FORM

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

| | PICA | | | | | | | | | | | CMS | S1500 PAG | GE 2 OF 8 | PICA | | |
|--|------------------------|----------------|-----------------|------------------|----------------|------------------|-------------|-------------|-------------------------|----------------|-----------------------------------|---------------------------|--------------------|---------------------------|----------------------|--|--|
| 1. MEDICARE (Medicare#) | MEDICAID (Medicaid# | TRICARE | #/DoD#) | CHAMPVA (Member | | UP HEALT | TH PLAN | | | OTHER X (ID#) | | RED'S I.D. NI | JMBER | (For Pr | ogram in item 1) | | |
| | ME(Last Name, Firs | | | 3. P | ATIENT'S BI | RTH DAT | E ¦ | | SEX | | 4. INSU | | | | , Middle Initial) | | |
| 5. PATIENT'S ADI | DRESS (NO.,Street |) | | | ATIENT REL | _ | _ | _ | | | 7. INSURED'S ADDRESS (NO.,Street) | | | | | | |
| , ST. #208 802 | O DE PALMA | | STATE | Sel | | Spouse | | Child | Other | Х | CITY | | | | CTATE | | |
| CITY | | | CA | 8. 8 | ESERVED F | OR NUCC | USE | | | | LOS AI | NGELES | | | STATE CA | | |
| ZIPCODE | TELER | PHONE(Inclu | ıde Area Coo | de) | | | | | | | ZIPCOD | E | TE | ELEPHONE(I | nclude Area Code) | | |
| 90713 | | 9) 612-314 | | | | | | | | | 90017 | | | | | | |
| 9. OTHER INSURE | D'S NAME(Last Na | ame, First Na | me, Middle I | nitial) 10. I | S PATIENT'S | S CONDIT | FION RE | ELATED TO |): | | | RED'S POLIC RED'S DATE | | OR FECA NU | MBER SEX | | |
| a. OTHER INSURE | D'S POLICY OR GE | ROUP NUMB | ER | a. E | MPLOYMEN | T?(Currer YES | nt or Pre | | | | M. IN 301 | 1 | DD | YY | м | | |
| b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? YES NO D. AUTO ACCIDENT? PLACE (State) D. OTHER CLAIM ID (Designated by NUCC) 32145689-1 Value | | | | | | | | | | | | | lue | | | | |
| c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | AME | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) Value d. IS THERE ANOTHER HEALTH BENIFIT PLAN? X Yes No If yes, complete items 9,9a, and 9d. | | | | | | | | | | | | | | | | | |
| READ BACK OF FORM BEFORE COMPLETEING & SIGNING THIS FORM 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize | | | | | | | | | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATUREI authorize the release of any medical or other information necessary to process this payment of medical benifits to the undersigned physician or supplied | | | | | | | | | | | ed physician or supplier | | | | | | |
| claim. I also reque assignment below | | rnment benif | its either to r | nyself or to go | vernment be | enifits eith | ner to m | yself or to | the party who ac | ccepts | for servi | ce described | below. | | | | |
| | GNATURE ON F | ILE | | | DAT | E 10/1 | 10/202 | 23 | | | S | IGNED | | | | | |
| | ENT ILLNESS, INJU | ** | | | OTHER DATE | , | N41-1 | 1 | DD 1 | V/V | 16. DATE | S PATIENT U | JNABLE TO | WORK IN CU | RRENT OCCUPATION | | |
| MM Value | DD Value | YY Value | QUAL. | QU | AL. į | - ! | MM Value | ١ | DD √alue ¦ | YY Value | FF | ROM ! | MM DD | <u>; ^{үү} тс</u> | MM DD YY | | |
| 17. NAME OF REF | ERRING PROVIDER | OR OTHER S | SOURCE | | 17.a | | | | | | 18. HOSI | | | V /V | URRENT SERVICES | | |
| | | | | | 17.b | | | N | PI | | | | MM DD | |) | | |
| 19. DATES PATIEN | IT UNABLE TO WO | RK IN CURRE | NT OCCUPA | TION | | | | | | | 20. OUT | SIDE LAB? es No | \$CHARG | ES | | | |
| | | | | | | | | | | | 22 . RESU | JBMISSION | | | | | |
| 21. DIAGNOSIS O | R NATURE OF ILLN | ESS OR INJU | JRY Relate A- | L to service lir | ne below(24 | Ξ) | | | ICD Ind. | 10 | CODE | OF I | RIGINAL REF | . NO. | | | |
| A. <u>A009</u> | _ | 3. A009 | | C. | Value | | | | alue | | 23. PRIO | R AUTHORIZ | ZATION NUI | MBER | | | |
| E. Value I. Value | | . Value | | G. K. | Value Value | | | | 'alue 'alue | | | | | | | | |
| 24. A. DATE(S) OF | SERVICE | B. | C. | D. PROCEDUR | ES, SERVICE | S, OR SU | PPLIES | | E. | | F. | G. | H. | I. | J. | | |
| From | To | PLACE OF | AMG | | plain Unusua | 1 | DIAGNOSIS | \$ CH | ARGES | DAYS OR | EPSDT | ID QUAL. | RENDERING PROVIDER | | | | |
| ו ז טט ויוויו | MM DD YY | SERVICE | | CPT/HCPC | 5 | MOD | IFIER | | POINTER | | | UNITS | Family Plan | ZZ | 1215628623 | | |
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| 11 01 23 | 1 1 | '' | | 37013 | | | | ! | A ,U ,C ,U | 140 | . ' | ' | 004 | NPI | | | |
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| 11 01 23 | | 11 | | 97814 | | | | | A ,B ,C ,D | 114 | 06 | 1 | 004 | NPI | 1144239401 | | |
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| 25. FEDERAL TAX | I.D NUMBER | | SSN EIN | 26. PATIEN | IT'S ACCOU | NT NO. | | | T ASSIGNMENT | | ١ . | L CHARGE | 29. AMOU | NT PAID 3 | 0. Rsvd for NUCC Use | | |
| 330184132 | | | | 477DRG | 9122800-1 | | | | claims, see back) ES |) No | \$. | 1055 .3 | \$ (| 00.00 | o .00 | | |
| 31. SIGNATURE O | F PHYSICIAN OR S | UPPLIER INC | LUDING | 32. SERVICI | E FACILITY L | | I INFOR | | | | 33. BILLII | NG PROVIDE | R INFO & PH | H #() | | | |
| | DENTIALS (I certif | • | | | Shaw Ave | | | | | | WorkM PO BO | led Califor X 3327 | nıa, APC | | | | |
| the reverse apply Kevin Calhoun | to this bill and are m | nade a part th | nereof.) | | Shaw Ave | | nia | | | | Seal R | each Calif | ornia | 90 | 740 | | |
| SIGNATURE O | N FILE | 10/10/2 | | | 187029279 | | | | | | | | | | | | |
| DATE a. N 1487029278 b. a. a. | | | | | | | | | | a. 111 | N 1487029278 b. | | | | | | |