HEALTH INSURANCE CLAIM FORM

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

AMTRUST NORTH AMERICA

SUBMITTED ELECTRONICALLY VIA DATA DIMENSIONS

CARRIER

CMS1500 PAGE 1 OF 1

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 613-02-9476

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LETICIA GARCIA

3. PATIENT'S BIRTH DATE MM DD YY: 05 15 72 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): LETICIA GARCIA

5. PATIENT'S ADDRESS (No., Street): 12790 MERIT DR STE 200

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

7. INSURED'S ADDRESS (No., Street): 12790 MERIT DR STE 200

CITY: DALLAS STATE: TX

8. RESERVED FOR NUCC USE

ZIP CODE: 75251 TELEPHONE (Include Area Code): (323) 873-0827

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? X YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 05 15 72 X

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? X YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC) X

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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 SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for 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 OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 01 17 17

17a.

17b. NPI

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

A. Z710 B. C. D. 01

E. F. G. H.

I. J. K. L.

INTERPRETING SERVICES - PERLA RAMIREZ

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1						SEE ATTACHED				NPI	
2	01 17 17 01 17 17	11		T1013	A		280	8		NPI	ZZ 1063480192
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 47-1397278 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 for NUCC Use

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.) X

SIGNED PERLA RAMIREZ KM DATE 12/06/2022

32. SERVICE FACILITY LOCATION INFORMATION: 477DB9122800-1

LOS ANGELES

5860 AVALON BLVD

a. LOS ANGELES b. CALIFORNIA

33. BILLING PROVIDER INFO & PH # 280 ( ) (310) 756-9887

SERENITY INTERPRETING SERVICES

a. 1534 S MESA ST b.

SAN PEDRO CALIFORNIA 90731

1215628623

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)