AMTRUST NORTH AMERICA
-

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA

CMS1500 PAGE 1 OF 8 PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLACKLUNG [ ] (ID#) OTHER [x] (ID#)	1.a INSURED'S I.D. NUMBER (For Program in item 1): 000-00-0000
2. PATIENT'S NAME(Last Name, First Name, Middle Initial): MILANA, CHRIS	3. PATIENT'S BIRTH DATE MM DD YY SEX M [x] F [ ]	4. INSURED'S NAME(Last Name, First Name, Middle Initial): MERAKI RCM SOLUTIONS, LLC
5. PATIENT'S ADDRESS (NO.,Street): , ST. #208 8020 DE PALMA	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [x]	7. INSURED'S ADDRESS (NO.,Street)
CITY: LAKEWOOD STATE: CA	8. RESERVED FOR NUCC USE	CITY: LOS ANGELES STATE: CA
ZIPCODE: 90713 TELEPHONE(Include Area Code): , (909) 612-3145		ZIPCODE: 90017 TELEPHONE(Include Area Code):
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) [x] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): 32145689-1 Value
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Value
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	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

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

14. DATE OF CURRENT ILLNESS, INJURY,or PREGNANCY (LMP) MM Value DD Value YY Value QUAL.	15. OTHER DATE QUAL. MM Value DD Value YY Value
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17.a 17.b NPI
19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 10	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
A. A009 B. Value C. Value D. Value E. Value F. Value G. Value H. Value I. Value J. Value K. Value L. Value	20. OUTSIDE LAB? [ ] Yes [ ] No $CHARGES 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	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	11 01 23	11		99214		A	392 58	1	004	ZZ NPI	1215628623 1144239401
2	11 01 23	11		WC002			0 0	1	004	ZZ NPI	1215628623 1144239401
3	11 01 23	11		97750		A ,B ,C ,D	106 62	1	004	ZZ NPI	1215628623 1144239401
4	11 01 23	11		97124		A ,B ,C ,D	95 62	1	004	ZZ NPI	1215628623 1144239401
5	11 01 23	11		97810		A ,B ,C ,D	117 86	1	004	ZZ NPI	1215628623 1144239401
6	11 01 23	11		97811		A ,B ,C ,D	87 86	1	004	ZZ NPI	1215628623 1144239401

25. FEDERAL TAX I.D NUMBER SSN [ ] EIN [ ] 330184132	26. PATIENT'S ACCOUNT NO. 477DB9122800-1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO	28. TOTAL CHARGE $ 1055 .3 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.) Kevin Calhoun SIGNATURE ON FILE 10/10/2023 - DATE	32. SERVICE FACILITY LOCATION INFORMATION Fresno-New 2440 W Shaw Ave #106 2440 W Shaw Ave #106 Fresno California a. NPI 1487029278 b.	33. BILLING PROVIDER INFO & PH #( ) WorkMed California, APC PO BOX 3327 Seal Beach California 90740 a. NPI 1487029278 b.	

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5. PATIENT'S ADDRESS (NO.,Street): , ST. #208 8020 DE PALMA

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

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

CITY: LAKEWOOD STATE: CA

8. RESERVED FOR NUCC USE

CITY: LOS ANGELES STATE: CA

ZIPCODE: 90713 TELEPHONE(Include Area Code): , (909) 612-3145

ZIPCODE: 90017 TELEPHONE(Include Area Code):

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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? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 32145689-1 Value

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Value

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17.a

17.b NPI

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

19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

20. OUTSIDE LAB? ☐ Yes ☐ No $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 10

A.	A009	B.	A009	C.	Value	D.	Value
E.	Value	F.	Value	G.	Value	H.	Value
I.	Value	J.	Value	K.	Value	L.	Value

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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.#
														ZZ	1215628623
1	11	01	23			11		97813		A ,B ,C ,D	140 7	1	004	NPI	1144239401
														ZZ	1215628623
2	11	01	23			11		97814		A ,B ,C ,D	114 06	1	004	NPI	1144239401
3															
4															
5															
6															

25. FEDERAL TAX I.D NUMBER 330184132 SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO. 477DB9122800-1

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

28. TOTAL CHARGE $ 1055 .3

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.)
Kevin Calhoun
SIGNATURE ON FILE 10/10/2023
- DATE

32. SERVICE FACILITY LOCATION INFORMATION
Fresno-New
2440 W Shaw Ave #106
2440 W Shaw Ave #106
Fresno California
a. NPI 1487029278 b.

33. BILLING PROVIDER INFO & PH #( )
WorkMed California, APC
PO BOX 3327
Seal Beach California 90740
a. NPI 1487029278 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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