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 [ ] (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 i 100-00-0200
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jose Rodriguez	3. PATIENT'S BIRTH DATE MM DD YY SEX 10 01 72 M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street) 8020 De Palma St. #208	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]
CITY Downey STATE CA	8. RESERVED FOR NUCC USE
ZIP CODE 90241 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) [X] YES [ ] NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

CITY STATE 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) Y4 claimnu12345	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
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 SIGNATURE ON FILE DATE 11/11/2022

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. 01 28 22	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP MM DD YY FROM TO MM DD
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERV MM DD YY FROM TO MM DD
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? $ CHARGES [ ] YES [ ] NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. B. C. D. E. F. G. H. I. J. K. L.		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	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDE PROVID
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

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 $	29. AMOUNT PAID $ 0.00
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.) Halo Services Inc Signature on File 12/06/2022 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION City of Industry City of Industry City of Industry2 City of Industry California a. 91744-9174 NPI b.		33. BILLING PROVIDER INFO & PH # (877) 285-26 Halo Services Inc P.O. Box 1968 Montebello California 90640 a 28-4144036 NPI b.	

NUCC Instruction Manual available at: www.nucc.org