

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE	(NUCC) 02/12								PICA TT
1. MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP	FECA	OTHER	1a. INSURED'S I.D. N	UMBER		(For Program	
(Medicare#) (Medicaid#) (ID#/DoD#)	(Member ID	HEALTH PI	LAN FECA BLK LL (ID#)	JNG X (ID#)	non link sungrubnio	a widilaub		(i or i rogical	the patient is r
2. PATIENT'S NAME (Last Name, First Name, Middle Initial))	3. PATIENT'S BIRT	TH DATE	SEX	4. INSURED'S NAME	(Last Name	e, First Name	e, Middle Initial)	oald 384 397 eshed Lock show
OWEN, KARL	A result of the first		1990 X	my processory					
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)				The receiver adT	
3141 STEVENS CREEK BOU	T.E.VARD	Self Spous	se Child	Other X	atelia e an ante				
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95117 (408) 59722		AC IO DATIENTIO	OCUPITION DE	1750 70	**	OV ODOUG	ODEFOAR)	and the pool of the
9. OTHER INSURED'S NAME (Last Name, First Name, Midd	idie initial)	10. IS PATIENT'S	CONDITION REL	ATED TO:	11. INSURED'S POLIC	JY GHOUP	OH FECA I	NUMBER	
OWEN, KARL	MA TAKENAME E		. (0	nthe jackgaled fa Mühl y ektor tokk	es isun yedi (s. si		500	OFV.	NO E OBJANSYNS)
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE (OF BIRTH		SEX	-
1363513570	ETHORENU BAN IC	r mrus gal	YES X	10	61 ONE (86VO 576 F	12 101 1 16		М	3 F/ OH IT 103
b. RESERVED FOR NUCC USE		b. AUTO ACCIDEN		PLACE (State)	b. OTHER CLAIM ID (Designated	by NUCC)		
•	400 ACL 02	S& armir	YES X	10					41 20 20 20 20
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME					
ust abou couvering be support to livin suc litthrebulue.	siesupen shijuri	YES X	10	VOTICE: Any c					
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
	E OF MEDICARE TRICARE, FECA, AND BL			X YES	NO .	<i>If yes</i> , comp	elete items 9, 9a,	and 9d.	
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 necessar					13. INSURED'S OR AL				
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of governmen 				payment of medical benefits to the undersigned physician or supplier for services described below.				or supplier for	
below. SIGNATURE ON FILE	digita way entreselved been now whereboat been			SIGNATURE ON FILE					
SIGNED	DATE			SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANC				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY				UPATION	
MM DD YY QUAL	AL. MM DD YY			FROM TO TO					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
	NPI			FROM D	DY		MM DD	YY	
17b. NPI 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES				
					YES X NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Re	olato A.I. to convic	oo lino bolow (245)		94 to reviseacia	luminos luminos	INO	U-10. Alexa	5	O NOWO RON
	elate A-L to servic	se line below (242)	ICD Ind. 0		22. RESUBMISSION CODE		ORIGINAL	REF. NO.	
A. [F902] B. [с. Ц	massio ya tabiw	D. L	60) 50 (Block	OR DELOE ALTHOU	ZATIONIAU	MDED		AACART RUM
E F	н. 🗠			23. PRIOR AUTHORIZATION NUMBER					
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24. A. DATE(S) OF SERVICE B. C. From To PLACE OF		OURES, SERVICES n Unusual Circumst		E. DIAGNOSIS	palagas as nuenco a	G. DAYS	H. I. EPSDT Family ID.	REN	J. IDERING
MM DD YY MM DD YY SERVICE EM			IODIFIÉR	POINTER	\$ CHARGES	OR	Plan QUAI		IDER ID. #
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							NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN 2	26. PATIENT'S AG	DCOUNT NO.	27. ACCEPT A	SSIGNMENT?	28. TOTAL CHARGE	29.	NPI AMOUNT F		svd for NUCC Us
			27. ACCEPT A For govt. clair	ASSIGNMENT?			AMOUNT F	PAID 30. Rs	svd for NUCC Us
812344400 X	744-228	30	X YES		\$ 120	00 \$	AMOUNT F	PAID 30. Rs	SAUTAG
812344400 XX 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	744-228 32. SERVICE FAC	3 0 CILITY LOCATION I	X YES [NO	\$ 120	00 \$	AMOUNT F	O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-2439
812344400 X 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	744-228 32. SERVICE FAC SERENIT	30 CILITY LOCATION I	X YES [INFORMATION SELING	NO SERVI	\$ 120 33. BILLING PROVIDE SERENITY	00 \$ ER INFO & COU	AMOUNT F C PH# (8 VSELI	0 00 30. Rs 0 00 468 ING SER	-2439 VI
812344400 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.)	744-228 32. SERVICE FAC SERENIT 99-149	30 CILITY LOCATION I FY COUNS MOANALU	X YES [INFORMATION SELING	NO SERVI	\$ 120 33. BILLING PROVIDE SERENITY 99-149 MG	00 \$ ER INFO & COUL OANA	AMOUNT F 0 PH# (8 NSELI LUA R	0 00 30. Rs 0 00 468 ING SER	-2439 VI
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