

TRIWEST HEALTHCARE ALLIANCE PC3

HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE MEDICAID TRICARE	CHAMPVA GROU	JP TH PLAN FECA BLK LUNG (ID#)	OTHER X (ID#)				(For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#)	rise modification in the second	(ID#)	X (ID#)	101480353		2	er to presing the soull ARACIET
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		BIH IH DATE S	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
PATTERSON, ANTHONY 5. PATIENT'S ADDRESS (No., Street)		3 1984 X	the state of the s		Y		
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94-510 KUPUOCHI ST 201	STATE 8. RESERVED		Other	94-510 KU	PUOCE	11 5.	I ZUI STATE
WAIPAHU	HI	STOR NOCC USE		WAIPAHU			HI
ZIP CODE TELEPHONE (Include Area Co				ZIP CODE	Т	ELEPHON	E (Include Area Code)
96797 (414) 202925	0			96797	s Altesteolau d ma scoloa	(414	4) 2029250
9. OTHER INSURED'S NAME (Last Name, First Name, Middle In		T'S CONDITION RELAT	ED TO:	11. INSURED'S POLICY	Y GROUP OF		
PATTERSON, ANTHONY	etosayrig a mexecia in this science in the second as the tri						
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYM	ENT? (Current or Previou	ıs)	a. INSURED'S DATE O	FBIRTH		SEX
1014803537	ary mamber of the Unit	YES X NO		$01 \mid 13 \mid$	1984	M	X
b. RESERVED FOR NUCC USE	b. AUTO ACC	DIDENT? PI	_ACE (State)	b. OTHER CLAIM ID (D	esignated by	NUCC)	en Lasalia e
	10 ACK (17 1 10 1 10 1 10 10 10 10 10 10 10 10 10	YES X NO					
c. RESERVED FOR NUCC USE	c. OTHER AC			c. INSURANCE PLAN N	NAME OR PF	OGRAM N	NAME
mit may upon convictor be subject to link and imanisummer	uningarym) are and discellus ad residence room can intel end plusies on a Yes 1 in X no an execut			NOTICE: Any c use or latelyes expended interregion in constitution of the constitution			
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM C	ODES (Designated by N	UCC)	d. IS THERE ANOTHER	R HEALTH BI	ENEFIT PL	AN?
ARE ESCA and Black Luna programs. Authority to oster	TEST energy basis and to a	olialainehe est ni ba	raen noden				te 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 necessary							SIGNATURE I authorize ned physician or supplier for
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment				services described below.			
SIGNATURE ON FILE				SIGN	IATURI	ON	FILE setsmoles will
SIGNED	DAT			SIGNED			West of the state
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (L	MP) 15. OTHER DATE	MM DD	YY		NABLE TO V		CURRENT OCCUPATION MM DD YY
QUAL.				FROM	DATES DEL	ATED TO	
	17a. NPI			18. HOSPITALIZATION MM DD FROM	YY	TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		ensolverin remach be	70-0801, 181	20. OUTSIDE LAB?	ze n eston Sibti was tan		HARGES
					NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				22. RESUBMISSION			
A F331	s and the plantage and a	ICD Ind.		CODE	OF	RIGINAL F	EF. NO.
			1000000	23. PRIOR AUTHORIZATION NUMBER			
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