

# HEALTHCARE CLAIM FORM – OUTPATIENT VISIT

## ***Patient & Member Info***

Claim ID: CLM-2025-0001

Member ID: M123456789

Patient Name: John Doe

Date of Birth: 05/10/1985

## ***Provider Info***

Provider Name: BrightCare Family Clinic

Provider NPI: 1234567890

Tax ID: 12-3456789

## ***Service Details***

Service Date From: 01/10/2025

Service Date To: 01/10/2025

## ***Charges***

Total Charge Amount: 165.00

Payment Method: Insurance

Notes: Office visit with rapid strep test

Line	CPT/HCPCS Code	ICD-10 Code	Units	Line Amount
1	99213	J01.90	1	120.00
2	87880	J01.90	1	45.00