HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): SRH-0401-2994-91-GPT

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FLAHERTY, NIKA M

3. PATIENT'S BIRTH DATE MM DD YY: 09 00 2008 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FLAHERTY, BABAK H

5. PATIENT'S ADDRESS (No., Street): 1095 SW 129TH BLVD, ROBINSON PARK

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): # 45 LAKE VIEW TOWERS, HARRINGTON RD

CITY: SOUTH MIAMI STATE: IM

8. RESERVED FOR NUCC USE

CITY: TUCSON STATE: IM

ZIP CODE: 85700 TELEPHONE (Include Area Code): (834) 601-4485

ZIP CODE: 85700 TELEPHONE (Include Area Code): (765) 235 - 5916

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): FLAHERTY, DAVID B

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 05011999231

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1948970101456

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State)

OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: RUBYX PLATINUM GEMS SOC TIER1

d. INSURANCE PLAN NAME OR PROGRAM NAME: GHEALTH MEDIC

10d. CLAIM CODES (Designated by NU

IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9a, and 9...

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: DAVID FLAHERTY DATE: 07 / 05 / 2021

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: FLAH SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES 15 26

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 0881.56 B. NX2163 C. D. G816

E. F. S99 G. H.

I. J. K.

22. RESUBMISSION CODE G45 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 555558888866

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. RENDERING PROVIDER ID. #
1	10	26	20			16		93522	10	B14	1734 00	06		NPI	54218922
2	12	30	22			08	Y	J45302	RT	FJ	1467 00	11.5		NPI	199924325
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 47233-1125-065 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 2131378414612

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 3201 00

29. AMOUNT PAID: $ 1700 00

30. Rsvd for NUCC Use

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.)

DAVID FLAHERTY JULY 13, 2021

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

DR ROY'S SPECIALITY HEALTH CLINIC
EDMONTON DE 41522
MANATEE GARDENS, SEASIDE

a. 3665422837 b.

33. BILLING PROVIDER INFO & PH # (789)832-7445

PAYING TO: IBP CLAIMS LEGALAID
PO BOX 60115 FORM SAR EAST SIDE
WHITEROCK GARDENS CALI CX 87710-1045

a. 54218922 b.