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 [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): RTU121944182300100

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DREISBACH, JEREMIAH T

3. PATIENT'S BIRTH DATE MM DD YY: 09 16 2021 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DREISBACH, THOMPSON R

5. PATIENT'S ADDRESS (No., Street): 255 CALEO BAY AVE

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

7. INSURED'S ADDRESS (No., Street): 255 CALEO BAY AVE

CITY: STUTTGART STATE: DE

8. RESERVED FOR NUCC USE

CITY: CALEO BAY STATE: DE

ZIP CODE: 61164 TELEPHONE (Include Area Code): (765) 655-4855

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): DREISBACH, THOMPSON R

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 0045781245

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 852963147

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

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

b. RESERVED FOR NUCC USE

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

OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAID NON UNION

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAID

10d. CLAIM CODES (Designated by NU

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

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: 18/02/2022

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: SIGNATURE ON FILE

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 TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES 20062 65

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

A. E878.8 B. R18 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 9D99999C66

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 06 18 21		11	Y	T3544		AA	85 50	004	Y	NPI	23412882
2 04 14 22		22	Y	ZX455		BA	105 45	90		NPI	S662585236
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [X] EIN [ ]: 878995114

26. PATIENT'S ACCOUNT NO.: 3225896461452

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

28. TOTAL CHARGE: $ 190 95

29. AMOUNT PAID: $ 190 95

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.)

SIGNED: SIGNATURE ON FILE DATE: 02/19/2022

32. SERVICE FACILITY LOCATION INFORMATION

DR KIMBERLY CARE CENTER
WEST CHERRY AVE
PA 843255

a. 2354 b.

33. BILLING PROVIDER INFO & PH # (785) 558-7339

PAY TO: LEGAL CLAIMS SETTLEMENT OFFICE
PO BOX 61158
WEST HILL IL 83345-1211

a. b.