HEALTH INSURANCE CLAIM FORM

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

PICA

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): SFG1241010247800

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PRIMA, NASH

3. PATIENT'S BIRTH DATE MM 11 DD 14 YY 20 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PRIMA, HELEN N

5. PATIENT'S ADDRESS (No., Street): 6401 NEWS PLAZA PLACITA LUREP

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

7. INSURED'S ADDRESS (No., Street): 6401 N PLACITA ALTA REPOSA

CITY: NASHVILLE | STATE: NV

8. RESERVED FOR NUCC USE

ZIP CODE: 500543 | TELEPHONE (Include Area Code): (934) 283 -4328

ZIP CODE: 500543 | TELEPHONE (Include Area Code): (822) 714-5614

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): PRIMA, HELEN N

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 0222158936

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] 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: NORTH GREEN UNION

d. INSURANCE PLAN NAME OR PROGRAM NAME: OTH MEDICAID

10d. CLAIM CODES (Designated by NUCC)

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: READ BACK OF FORM BEFORE COMPLETING & SIGNING. 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: 06/12/2025

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: NFTO

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 0 00

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

A. G818 B. R52145 C. S8994 D. E. F. G. H. I. J.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 9999996N6

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	$ CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. ID. QUAL.	I. RENDERING PROVIDER ID. #
1	4 14 23		01	Y	8505	UT	BB	535 50	004		NPI 8811528877
2	09 29 24		19	Y	87789	NP	A04	600 00	003		NPI 8811528877
3	09 29 24		19	Y	8773.19	NU	AA	600 00	003		NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER | SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 685222014612

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

28. TOTAL CHARGE: $ 1795 50

29. AMOUNT PAID: $ 1005

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: 06 DEC 2021

32. SERVICE FACILITY LOCATION INFORMATION: 8RICK ROUTE 88 ST DAHLIA GROUNDS 22ND ST

a. 24202301 | b.

33. BILLING PROVIDER INFO & PH #: (795) 858 - 7339

PAY TO: S.E.C.D. PEARSON MILWAKEE PO 452-41

a. 87899553164 | b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-1

CARRIER

PATIENT AND INSURED INFORMATION

INFORMATION ABOUT THE APPLICANT'S OR SUPPLIER

MEDICAID RECLAIMATION CLAIMS