



PRIVATEPAY

HEALTH INSURANCE CLAIM FORM

UNKNOWN, CO 00000

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 09151975	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ANGEL, THEODORE ' JIMMY '		3. PATIENT'S BIRTH DATE MM DD YY 09151975 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 6002 GRAPE DR CITY COMMERCE CITY STATE CO ZIP CODE 80022 TELEPHONE (Include Area Code) (720)4610920		4. INSURED'S NAME (Last Name, First Name, Middle Initial) ANGEL, THEODORE ' JIMMY '	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 6002 GRAPE DR CITY COMMERCE CITY STATE CO ZIP CODE 80022 TELEPHONE (Include Area Code) (720)4610920	
8. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY 09151975 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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. SIGNATURE ON FILE SIGNED _____ DATE 06292023		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN BETHANY WALLACE MD		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. G89.11 B. M47.896 C. M51.26 D. M54.12 E. M54.16 F. M54.2 G. M62.830 H. S13.4XXD I. S16.1XXD J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. 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. #		23. PRIOR AUTHORIZATION NUMBER	
1 06282023 06282023 11 99214 ABCD 736.00 1 NPI 1033300140			
2			
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25. FEDERAL TAX I.D. NUMBER SSN EIN 814336438 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 10952659A	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 736.00	
29. AMOUNT PAID \$ 0.00		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.) JACK RENTZ MD 06292023 SIGNED _____ DATE		32. SERVICE FACILITY LOCATION INFORMATION DENVER DIAGNOSTIC PAIN, LLC 8515 PEARL STREET STE 201 THORNTON, CO 80229-4809 a. 1033300140 b.	
33. BILLING PROVIDER INFO & PH # (720)5980805 JACK RENTZ MD 7800 E Orchard Rd Ste 350 Greenwood Village, CO 80111 a. 1033300140 b.			