HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER 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): 89442808
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Simpson, Homer	3. PATIENT'S BIRTH DATE MM DD YY: 05 12 1956 SEX M (X) F ( )		4. INSURED'S NAME (Last Name, First Name, Middle Initial): Simpson, Marge
5. PATIENT'S ADDRESS (No., Street): 742 Evergreen Terrace	6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )		7. INSURED'S ADDRESS (No., Street): 742 Evergreen Terrace
CITY: Springfield STATE: IL	8. RESERVED FOR NUCC USE		CITY: Springfield STATE: IL
ZIP CODE: 62704 TELEPHONE (Include Area Code): (555) 555-6392			ZIP CODE: 62704 TELEPHONE (Include Area Code): (555) 555-6393
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Simpson, Abraham	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER: 123456789
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 21173018	a. EMPLOYMENT? (Current or Previous) (X) YES ( ) NO		a. INSURED'S DATE OF BIRTH MM DD YY: 08 12 1960 SEX M ( ) F (X)
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? (X) YES ( ) NO PLACE (State): KS		b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ( ) YES (X) NO		c. INSURANCE PLAN NAME OR PROGRAM NAME: Independence Blue Full Coverage
d. INSURANCE PLAN NAME OR PROGRAM NAME: Independence Blue Cross Blue Shield	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES ( ) NO *If yes*, complete items 9, 9a, and 9d.

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 _____ DATE _____

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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 02 2024 QUAL:	15. OTHER DATE QUAL: MM DD YY:	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 04 02 2024 TO 04 20 2024
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Kevin Smith	17a. 17b. NPI: 2490433892	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 03 30 2024 TO 05 21 2024
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? (X) YES ( ) NO $ CHARGES: 125 USD
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. J20 B. G89.4 C. XYZ3 D. XYZ4 E. XYZ5 F. XYZ6 G. XYZ7 H. XYZ8 I. XYZ9 J. XYZ10 K. L.		22. RESUBMISSION CODE: Prior Claim ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 0923092390

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	04	14	2024			IA	X				$1,000.00	20 days	None	NPI	
2	05	15	2024			IA	X				$2,000.00	10 days	None	NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 5551844680	26. PATIENT'S ACCOUNT NO.: 429802409	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ( ) YES ( ) NO	28. TOTAL CHARGE: $ 1,000.00	29. AMOUNT PAID: $ 320	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 DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # (555) 555-9391 Kevin Smith 2904 Main Street, Elizabeth, MD, 21219 a. 2490433892 b.		

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form