



MEDICARE OF FLORIDA
PO BOX 44117

JACKSONVILLE FL 322314117

HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER <input checked="" type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 5VX7JK3UG42							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TAYLOR, FRANKLIN						3. PATIENT'S BIRTH DATE SEX MM DD YY 07 26 1943 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) 6611 12TH ST W						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)							
CITY BRADENTON			STATE FL			8. RESERVED FOR NUCC USE						CITY		STATE					
ZIP CODE 342075905			TELEPHONE (Include Area Code) ()									ZIP CODE		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) SAME,						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER NONE							
						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>							
						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC) _____							
d. INSURANCE PLAN NAME OR PROGRAM NAME FLORIDA BLUE COMMERCIAL						10d. CLAIM CODES (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME _____							
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.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												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 DATE _____												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 FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN NINA LUNDBERG						17a. 1G 17b. NPI 1902200702						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NDC 00469650189												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.							
A. Z01810				B. _____ C. _____ D. _____				F. _____ G. _____ H. _____				I. _____ J. _____ K. _____ L. _____							
E. _____ F. _____ G. _____ H. _____				I. _____ J. _____ K. _____ L. _____				F. _____ G. _____ H. _____ I. _____ J. _____				F. \$ CHARGES G. DAYS OR UNITS H. EPDS/ Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #							
1	09	03	25	09	03	25	11	78452			A	1650	00	2	G2	203713889			
2	09	03	25	09	03	25	11	A9500			A	1000	00	2	NPI	1467449017			
3	09	03	25	09	03	25	11	93017			A	72	00	1	G2	203713889			
4	09	03	25	09	03	25	11	93016			A	41	00	1	NPI	1467449017			
5	N400469650189							J2785			A	40	00	4	G2	203713889			
6	09	03	25	09	03	25	11	93018			A	28	00	1	NPI	1467449017			
25. FEDERAL TAX I.D. NUMBER SSN EIN 203713889 <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. 50872				27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 2831		29. AMOUNT PAID \$ 0		30. Rsvd for NUCC Use 0 00			
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.) ROBERT J SUBBIONDO, 10 29 25 SIGNED DATE												32. SERVICE FACILITY LOCATION INFORMATION AMA HEART AND VASCULAR SPE 6001 21ST AVE W BRADENTON FL 342097847				33. BILLING PROVIDER INFO & PH # (941) 2634209 Arcadia Medical Associates PA 425 NURSING HOME DR ARCADIA FL 342663839			
												a. 1891980215 b. G2 203713889							