



MEDICARE OF FLORIDA  
PO BOX 44117

# HEALTH INSURANCE CLAIM FORM

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

JACKSONVILLE FL 322314117

XXX PICA										PICA XXX									
1. MEDICARE <input checked="" 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 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 MM DD YY 07 26 1943 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
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"/>									
CITY BRADENTON					STATE FL					7. INSURED'S ADDRESS (No., Street)					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 b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER XJJH84452392										11. INSURED'S POLICY GROUP OR FECA NUMBER NONE									
b. RESERVED FOR NUCC USE										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
c. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME FLORIDA BLUE COMMERCIAL										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. Signature On File SIGNED DATE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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 NINA LUNDBERG										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) A. Z01810 B. R9431 C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 09 03 25 09 03 25 11 78452 B 1650 00 2 G2 203713889 NPI 1467449017																			
2 09 03 25 09 03 25 11 A9500 B 1000 00 2 G2 203713889 NPI 1467449017																			
3 09 03 25 09 03 25 11 93017 A 72 00 1 G2 203713889 NPI 1467449017																			
4 09 03 25 09 03 25 11 93016 A 41 00 1 G2 203713889 NPI 1467449017																			
5 N400469650189 09 03 25 09 03 25 11 J2785 JZ A 40 00 4 G2 203713889 NPI 1467449017																			
6 09 03 25 09 03 25 11 93018 A 28 00 1 G2 203713889 NPI 1467449017																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 203713889 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 50872									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 2831 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.) ROBERT J SUBBIONDO, 11 24 25 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION AMA HEART AND VASCULAR SPE 6001 21ST AVE W BRADENTON FL 342097847 a. 1891980215 b.									
33. BILLING PROVIDER INFO & PH # (941) 2634209 Arcadia Medical Associates PA 425 NURSING HOME DR ARCADIA FL 342663839 a. 1891980215 b. G2 203713889																			