Medicaid Idaho
MCDID

HEALTH INSURANCE CLAIM FORM

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

Claim Id: 4015856759

PICA ☐ | PICA ☐

CARRIER

1. MEDICARE ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoD#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☒ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0003082385

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Tucker, Haley M	04 30 03	M ☐ F ☒	Tucker, Haley M

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
43720 silver valley rd	Self ☒ Spouse ☐ Child ☐ Other ☐	43720 silver valley rd

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Kingston	ID		Kingston	ID

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
83839	( )		83839	( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY: 04 30 03 SEX M ☐ F ☒
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid Idaho
d. INSURANCE PLAN NAME OR PROGRAM NAME	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 09/01/2025

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	QUAL. 0	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
	17b. NPI		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES: 0

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F603 B. F4312 C. F331 D. F1220
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 08 29 25	08 29 25	10		99205	95	ABCD	450.00	1		NPI	1295302339
2 08 29 25	08 29 25	10		90838	95	ABCD	325.00	1		NPI	1295302339
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd.for NUCC Use
332185708	☒	C34P69	☒ YES ☐ NO	$ 775.00	$ 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
MERRICKREYNOLDS		Moonlit Psychiatry 6211 S HIGHLAND DR 4025 Holladay UT 84121
SIGNED 09/14/2025 DATE	a. NPI b.	a. NPI 1275348807 b. 2084P0800X

PATIENT AND INSURED INFORMATION