

April 19, 2022

KEVIN CARROLL

597 FARMINGTON AVE.

HARTFORD CT 06105

Dear KEVIN CARROLL:

Enclosed please find your copy of the letter sent to .

Sincerely,



Elgoffshore User

Corporate Reimbursement/Subrogation Service Representative

BLUE CROSS BLUE SHIELD OF ILLINOIS

enc.

|  |  |
| --- | --- |
| Health Care Service Corporation | TELEPHONE NUMBER:  PAGE 1 OF 4 |

CONSOLIDATED STATEMENT OF BENEFITS

|  |  |  |  |
| --- | --- | --- | --- |
| **Subject to change.**  **Contact us for final amount prior to settlement**  PATIENT’S NAME: MARY PALENZA  HEALTH PLAN: BLUE CROSS BLUE SHIELD OF ILLINOIS  DATE OF INJURY: 03/25/2004  SERVICE PERIOD: 03/31/2004-01/18/2006  EVENT NUMBER: **HCSC** 4967222 | | | |
|  | | | |
| **Provider of Service** | **Claim Number** | **Billed Amt.** | **Provided Benefits** |
| **Date of Service** | **Diagnosis Code** |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200410655105980H** | **$259.00** | **$207.20** |
| 03/31/2004 | 721.3 LUMBOSACRAL SPONDYL |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200411855136000H** | **$97.00** | **$52.77** |
| 04/07/2004 | 724.5 BACKACHE UNSPEC |  |  |
| **GLASTONBURY PODIATRY GROU** | **0200419055234430H** | **$70.00** | **$31.61** |
| 04/14/2004 | 729.5 PAIN LIMB |  |  |
| **HEALTHSOUTH HOLDINGS INC** | **0200411355205540H** | **$264.00** | **$48.00** |
| 04/19/2004 | 724.2 SPONDYLOSIS W/O MYE |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200421955336540H** | **$180.00** | **$110.82** |
| 05/28/2004 | 923.20 CONTUSION HAND(S) |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200435855145820H** | **$103.00** | **$30.45** |
| 05/28/2004 | 959.4 HAND INJURY UNSPEC |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200427555216980H** | **$213.00** | **$62.43** |
| 05/28/2004 | 959.7 LOWER LEG INJURY UN |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200421955336510H** | **$90.00** | **$56.85** |
| 07/30/2004 | 724.5 BACKACHE UNSPEC |  |  |
| **RICHARD A GRANIERO** | **0200426755177820H** | **$141.00** | **$88.71** |
| 09/17/2004 | 724.5 BACKACHE UNSPEC |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200428755270600H** | **$307.00** | **$117.69** |
| 10/04/2004 | 715.14 LOCALIZED PRIMARY |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200502655641280H** | **$90.00** | **$56.85** |
| 10/12/2004 | 722.6 DISC DEGENERATION U |  |  |
| **HARTFORD HOSPITAL** | **0200512355145620H** | **$2868.84** | **$372.09** |
| 12/07/2004 | 719.45 PAIN JOINT PELVIC |  |  |
| **JEFFERSON HOUSE** | **0200514755407510H** | **$8190.00** | **$8045.93** |
| 12/08/2004 | 959.6 HIP/THIGH INJURY UN |  |  |
| **AMERICAN MED RESPO** | **0200501155180390H** | **$483.50** | **$288.32** |
| 12/08/2004 | 719.45 PAIN JOINT PELVIC |  |  |
| **HARTFORD HOSPITAL PROFESS** | **0200509455377540H** | **$180.00** | **$112.02** |
| 12/09/2004 | 724.5 BACKACHE UNSPEC |  |  |
| **AMERICAN MED RESPO** | **0200502155667790H** | **$562.50** | **$335.26** |
| 12/12/2004 | 724.2 SPONDYLOSIS W/O MYE |  |  |
| **AMERICAN MED RESPO** | **0200502155667780H** | **$483.50** | **$288.32** |
| 12/12/2004 | 724.2 SPONDYLOSIS W/O MYE |  |  |
| **HARTFORD HOSPITAL** | **0200512355145630H** | **$2806.71** | **$1122.43** |

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| **Provider of Service** | **Claim Number** | **Billed Amt.** | **Provided Benefits** |
| **Date of Service** | **Diagnosis Code** |
| 12/12/2004 | 738.4 ACQUIR SPONDYLOLIST |  |  |
| **AMERICAN HOMEPATIENT EAST** | **0200521555704800H** | **$534.95** | **$355.35** |
| 01/04/2005 | 722.2 DISC DISPLACEMENT U |  |  |
| **VNA HEALTH CARE, I** | **0200505555760520H** | **$456.00** | **$456.00** |
| 01/05/2005 | 719.45 PAIN JOINT PELVIC |  |  |
| **QUEST DIAGNOSTICS INC** | **0200520155731130H** | **$187.86** | **$49.47** |
| 01/11/2005 | 599.0 URIN TRACT INFECTIO |  |  |
| **QUEST DIAGNOSTICS INC** | **0200508855188720H** | **$25.20** | **$4.49** |
| 02/14/2005 | 716.90 UNSPEC ARTHROPATHY |  |  |
| **QUEST DIAGNOSTICS INC** | **0200508855188710H** | **$91.44** | **$18.19** |
| 02/14/2005 | 724.00 SPINAL STENOSIS UN |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200505555759110H** | **$222.00** | **$75.18** |
| 02/14/2005 | 724.00 SPINAL STENOSIS UN |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200505555240970H** | **$808.00** | **$233.48** |
| 02/16/2005 | 780.93 MEMORY LOSS |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200507155172340H** | **$91.00** | **$56.97** |
| 03/04/2005 | 724.00 SPINAL STENOSIS UN |  |  |
| **AMERICAN HOMEPATIENT EAST** | **0200521555703760H** | **$206.70** | **$129.69** |
| 03/04/2005 | 722.2 DISC DISPLACEMENT U |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200507155172350H** | **$213.00** | **$61.69** |
| 03/07/2005 | 729.5 PAIN LIMB |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200507655517470H** | **$91.00** | **$56.97** |
| 03/11/2005 | 722.6 DISC DEGENERATION U |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200508455558310H** | **$101.00** | **$52.74** |
| 03/21/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **I FLOW CORP** | **0200512555633070H** | **$340.00** | **$17.60** |
| 03/31/2005 | 715.94 OSTEOARTHROSIS UNS |  |  |
| **QUEST DIAGNOSTICS INC** | **0200523455452870H** | **$335.89** | **$61.00** |
| 04/26/2005 | 275.42 HYPERCALCEMIA |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200512655457950H** | **$198.00** | **$59.35** |
| 04/26/2005 | 272.4 HYPERLIPIDEMIA OTHE |  |  |
| **MANCHESTER MEMORIA** | **0200514755397780H** | **$1196.35** | **$717.82** |
| 05/12/2005 | 882.0 OPEN WOUND HAND |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200514655470470H** | **$860.00** | **$329.23** |
| 05/19/2005 | 996.4 MALFUNCT INT ORTHOP |  |  |

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| **Date of Service** | **Diagnosis Code** |
| **ORTHOPEDIC ASSOCIA** | **0200515855610430H** | **$4633.17** | **$868.50** |
| 05/19/2005 | 996.4 MALFUNCT INT ORTHOP |  |  |
| **HARTFORD ANESTHESIOLOGY A** | **0200516255145570H** | **$582.00** | **$270.00** |
| 05/19/2005 | V54.01 REMOVAL INT FIXATI |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200515255412520H** | **$91.00** | **$23.08** |
| 05/25/2005 | 715.14 LOCALIZED PRIMARY |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200517555279020H** | **$1184.00** | **$316.60** |
| 06/16/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **ORTHOPEDIC ASSOCIA** | **0200518055665720H** | **$1148.00** | **$562.50** |
| 06/16/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200520155155830H** | **$227.00** | **$89.25** |
| 07/06/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **ORTHOPEDIC ASSOCIA** | **0200520055112080H** | **$1722.00** | **$843.75** |
| 07/12/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200520155155840H** | **$1144.00** | **$198.33** |
| 07/12/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200522355679390H** | **$87.00** | **$40.40** |
| 08/03/2005 | 724.4 SPONDYLOSIS W/O MYE |  |  |
| **QUEST DIAGNOSTICS INC** | **0200525255699890H** | **$237.47** | **$48.77** |
| 08/25/2005 | 275.42 HYPERCALCEMIA |  |  |
| **QUEST DIAGNOSTICS INC** | **0200535755430940H** | **$140.95** | **$15.28** |
| 08/25/2005 | 275.42 HYPERCALCEMIA |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200525955674460H** | **$180.00** | **$121.12** |
| 09/08/2005 | 716.90 UNSPEC ARTHROPATHY |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200602755143770H** | **$103.00** | **$37.53** |
| 09/08/2005 | 719.43 PAIN JOINT FOREARM |  |  |
| **JEFFERSON XRAY GROUP INC** | **0200600555455410H** | **$220.00** | **$86.70** |
| 09/12/2005 | 275.42 HYPERCALCEMIA |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200528455074660H** | **$1269.00** | **$682.28** |
| 09/27/2005 | 724.02 SPINAL STENOSIS LU |  |  |
| **OPEN MRI AT BUCKLAND HILL** | **0200528755519020H** | **$2342.00** | **$1126.43** |
| 09/28/2005 | 724.2 SPONDYLOSIS W/O MYE |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200529455179610H** | **$101.00** | **$68.81** |
| 10/13/2005 | 724.02 SPINAL STENOSIS LU |  |  |
| **ORTHOPEDIC ASSOC OF HTFD** | **0200529755438630H** | **$91.00** | **$29.45** |

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| **Date of Service** | **Diagnosis Code** |
| 10/17/2005 | 715.14 LOCALIZED PRIMARY |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200530455119070H** | **$90.00** | **$75.69** |
| 10/20/2005 | 722.6 DISC DEGENERATION U |  |  |
| **NEUROSURGEONS OF CENTRAL** | **0200530755462650H** | **$275.00** | **$160.38** |
| 10/25/2005 | 724.02 SPINAL STENOSIS LU |  |  |
| **RHEUMATOLOGY ASSOCIATES P** | **0200530755462550H** | **$445.00** | **$307.42** |
| 11/01/2005 | 715.11 LOCAL PRIMARY OSTE |  |  |
| **CLINICAL LABORATOR** | **0200533355457160H** | **$202.22** | **$55.12** |
| 11/01/2005 | 725 POLYMYALGIA RHEUMATIC |  |  |
| **RHEUMATOLOGY ASSOCIATES P** | **0200532755473250H** | **$125.00** | **$68.81** |
| 11/15/2005 | 722.52 LUMB/SAC DISC DEGE |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200534355416430H** | **$669.00** | **$305.60** |
| 12/02/2005 | 729.5 PAIN LIMB |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200600555455420H** | **$283.00** | **$108.78** |
| 12/20/2005 | 782.3 EDEMA |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200600555455430H** | **$422.00** | **$152.00** |
| 12/20/2005 | 593.2 CYST KIDNEY ACQUIRE |  |  |
| **JEFFERSON X RAY GROUP INC** | **0200600555455440H** | **$299.00** | **$107.83** |
| 12/20/2005 | 241.0 NONTOXIC UNINODULAR |  |  |
| **RHEUMATOLOGY ASSOCIATES P** | **0200602555170160H** | **$515.00** | **$296.44** |
| 01/17/2006 | 719.09 EFFUSION JOINT MUL |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200602555170170H** | **$256.00** | **$78.50** |
| 01/17/2006 | 627.2 SYMP MENOPAUSAL STA |  |  |
| **PROHEALTH PHYSICIANS PC** | **0200602555795600H** | **$90.00** | **$60.56** |
| 01/18/2006 | 729.5 PAIN LIMB |  |  |
| **Total Billed Charges $42,521.25** | | **Total Benefits Provided $21,368.88** | |
| **Balance Due $21,368.88** | |  | |

HEALTH INSURANCE CLAIM FORM

1500

|  |  |
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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200419055234430H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 729.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $70 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  GLASTONBURY PODIATRY GROU SUITE 211  GLASTONBURY, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200421955336540H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 923.20 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | 724.5 | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $180 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200502655641280H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 722.6 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $90 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200521555704800H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 722.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 02 | | 04 | | 05 | |  | |  | | | | |  | E0260 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $534 | | | | | | | 95 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  AMERICAN HOMEPATIENT EAST PO BOX 827451  PHILADELPHIA, PA | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200522355679390H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $87 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200523455452870H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 275.42 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 04 | | 26 | | 05 | |  | |  | | | | |  |  | | | 82330 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
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| 04 | | 26 | | 05 | |  | |  | | | | |  | 82310 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $335 | | | | | | | 89 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  QUEST DIAGNOSTICS INC 3 STERLING DR  WALLINGFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200505555240970H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 780.93 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $808 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200525955674460H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 716.90 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $180 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200525255699890H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 275.42 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $237 | | | | | | | 47 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  QUEST DIAGNOSTICS INC 3 STERLING DR  WALLINGFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200528455074660H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.02 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 09 | | 27 | | 05 | |  | |  | | | | |  |  | | | 72100 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 1005 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 09 | | 27 | | 05 | |  | |  | | | | |  | K0648 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $1269 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200528755519020H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $2342 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  OPEN MRI AT BUCKLAND HILL PO BOX 230  GLASTONBURY, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200529455179610H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.02 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $101 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200529755438630H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 715.14 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $91 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200530455119070H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 722.6 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $90 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200530755462550H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 715.11 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 11 | | 01 | | 05 | |  | |  | | | | |  | 73030 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $445 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  RHEUMATOLOGY ASSOCIATES P SUITE 1003  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200530755462650H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.02 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $275 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  NEUROSURGEONS OF CENTRAL PO BOX 2229  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200532755473250H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 722.52 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $125 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  RHEUMATOLOGY ASSOCIATES P SUITE 1003  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200533355457160H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 725 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 11 | | 01 | | 05 | |  | |  | | | | |  |  | | | 86140 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 35 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 11 | | 01 | | 05 | |  | |  | | | | |  | 80076 | | | | | | |  | | | |  | | |  | |  | |
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| 11 | | 01 | | 05 | |  | |  | | | | |  | 85025 | | | | | | |  | | | |  | | |  | |  | |
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| 11 | | 01 | | 05 | |  | |  | | | | |  | 80051 | | | | | | |  | | | |  | | |  | |  | |
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| 11 | | 01 | | 05 | |  | |  | | | | |  | 82565 | | | | | | |  | | | |  | | |  | |  | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $202 | | | | | | | 22 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  CLINICAL LABORATOR A DR  NEWINGTON, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200533355457160H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 725 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $202 | | | | | | | 22 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  CLINICAL LABORATOR A DR  NEWINGTON, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200534355416430H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 729.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $669 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200535755430940H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 275.42 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $140 | | | | | | | 95 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  QUEST DIAGNOSTICS INC 3 STERLING DR  WALLINGFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200600555455410H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 275.42 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 09 | | 12 | | 05 | |  | |  | | | | |  |  | | | 78010 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $220 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON XRAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200602555795600H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 729.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $90 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

|  |  |
| --- | --- |
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200602555170160H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 719.09 | | | | | |  | | | | | | | | | | | | | | 3. | | 725 | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | 727.00 | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 01  1  2  3  4  5  6 | | 17 | | 06 | |  | |  | | | | |  | 20610 | | | | | | |  | | | |  | | |  | |  | |  | | | | | |  | |
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| 01 | | 17 | | 06 | |  | |  | | | | |  |  | | | 20550 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 145 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 01 | | 17 | | 06 | |  | |  | | | | |  | 99214 | | | | | | |  | | | |  | | |  | |  | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 40 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 01 | | 17 | | 06 | |  | |  | | | | |  | J1040 | | | | | | |  | | | |  | | |  | |  | |
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| 01 | | 17 | | 06 | |  | |  | | | | |  | J1040 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $515 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  RHEUMATOLOGY ASSOCIATES P SUITE 1003  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200602555170170H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 627.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $256 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200600555455420H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 782.3 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $283 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200600555455430H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 593.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $422 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200600555455440H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 241.0 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $299 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200602755143770H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 719.43 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $103 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200507155172350H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 729.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 03 | | 07 | | 05 | |  | |  | | | | |  |  | | | 73590 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $213 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200507655517470H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 722.6 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | 281.0 | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $91 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200508855188720H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 716.90 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $25 | | | | | | | 20 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  QUEST DIAGNOSTICS INC 3 STERLING DR  WALLINGFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200509455377540H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $180 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  HARTFORD HOSPITAL PROFESS PO BOX 40000  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200512555633070H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 715.94 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $340 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  I FLOW CORP 826 BREWER ST  EAST HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200514655470470H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 996.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $860 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200508455558310H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $101 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200507155172340H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.00 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. | 281.0 | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $91 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200508855188710H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.00 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $91 | | | | | | | 44 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  QUEST DIAGNOSTICS INC 3 STERLING DR  WALLINGFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200505555759110H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.00 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 02 | | 14 | | 05 | |  | |  | | | | |  |  | | | 82607 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 46 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $222 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200502155667790H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 12 | | 12 | | 04 | |  | |  | | | | |  |  | | | A0425 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 79 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 12 | | 12 | | 04 | |  | |  | | | | |  | A0800 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $562 | | | | | | | 50 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  AMERICAN MED RESPO 55 CHURCH ST  NEW HAVEN, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200502155667780H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 12  1  2  3  4  5  6 | | 12 | | 04 | |  | |  | | | | |  | A0428 | | | | | | |  | | | |  | | |  | |  | |  | | | | | |  | |
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| 12 | | 12 | | 04 | |  | |  | | | | |  |  | | | A0425 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $483 | | | | | | | 50 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  AMERICAN MED RESPO 55 CHURCH ST  NEW HAVEN, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200426755177820H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $141 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  RICHARD A GRANIERO 4 FARMSPRINGS RD  FARMINGTON, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200421955336510H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $90 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200411355205540H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 04 | | 19 | | 04 | |  | |  | | | | |  |  | | | 97140 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 45 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 04 | | 19 | | 04 | |  | |  | | | | |  | 97150 | | | | | | |  | | | |  | | |  | |  | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 29 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 04 | | 19 | | 04 | |  | |  | | | | |  | 97010 | | | | | | |  | | | |  | | |  | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $264 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  HEALTHSOUTH HOLDINGS INC DEPT AT  ATLANTA, GA | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200411855136000H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.5 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $97 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200410655105980H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 721.3 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 03 | | 31 | | 04 | |  | |  | | | | |  |  | | | 73510 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $259 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200435855145820H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 959.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $103 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200427555216980H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 959.7 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $213 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  JEFFERSON X RAY GROUP INC PO BOX 15202  NEWARK, NJ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200501155180390H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 719.45 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 12 | | 08 | | 04 | |  | |  | | | | |  |  | | | A0425 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $483 | | | | | | | 50 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  AMERICAN MED RESPO 55 CHURCH ST  NEW HAVEN, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200428755270600H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 715.14 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 10 | | 04 | | 04 | |  | |  | | | | |  |  | | | 73110 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $307 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200516255145570H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | V54.01 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $582 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  HARTFORD ANESTHESIOLOGY A PO BOX 540  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200517555279020H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $1184 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| --- | --- |
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200512655457950H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 401.9 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | 272.4 | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 46 | | | | 00 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 04 | | 26 | | 05 | |  | |  | | | | |  | 84450 | | | | | | |  | | | |  | | |  | |  | |
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| 04 | | 26 | | 05 | |  | |  | | | | |  | 84460 | | | | | | |  | | | |  | | |  | |  | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $198 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200512655457950H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 401.9 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. | 272.4 | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $198 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  PROHEALTH PHYSICIANS PC PO BOX 150473  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200515255412520H |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 715.14 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $91 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200520155155830H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 724.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $227 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200520155155840H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 724.4 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $1144 | | | | | | | 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.)    SIGNED DATE | | | | | | | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  ORTHOPEDIC ASSOC OF HTFD PO BOX 30845  HARTFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200520155731130H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | CODE | | | | | | | | | | | | | | | | ORIGINAL REF. NO. | | | | | | | | | | | | |
| 1. | 599.0 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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| 01 | | 11 | | 05 | |  | |  | | | | |  |  | | | 87077 | | | | | | |  | | | |  | | |  | |  | |  | | | | | | PHYSICIAN OR SUPPLIER INFORMATION | |
|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | 38 | | | | 89 | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
| 01 | | 11 | | 05 | |  | |  | | | | |  | 87086 | | | | | | |  | | | |  | | |  | |  | |
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| 01 | | 11 | | 05 | |  | |  | | | | |  | 81001 | | | | | | |  | | | |  | | |  | |  | |
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|  | |  | |  | |  | |  | | | | |  |  | | | | | | |  | | | |  | | |  | |  | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $187 | | | | | | | 86 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  QUEST DIAGNOSTICS INC 3 STERLING DR  WALLINGFORD, CT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only

HEALTH INSURANCE CLAIM FORM

1500

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| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | DCN: 0200521555703760H |

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| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER  CHAMPUS HEALTH PLAN BLK LUNG  *(Medicare #1)*  *(Medicaid #1)  (Sponsor’s SSN)  (VA File #)  (SSN or ID)  (SSN)  (ID)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1a. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000848173905 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT’S BIRTH DATE SEX | | | | | | | | | | | | | | | | | | | | 4. INSURED’S NAME (Last Name, First Name, Middle Initial)  PALENZA, MARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MM  05 | | DD  03 | | | | YY  1933 | | | | | | | M  F | | | | | | |
| 5. PATIENT’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | 7. INSURED’S ADDRESS (No., Street)  826 BREWER ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PATIENT AND INSURED INFORMATION | |
| CITY  EAST HARTFORD | | | | | | | | | | | | | | | | STATE  CT | | | | | | | | 8. PATIENT STATUS  Single MarriedOther  Employed Full-Time  Part-Time  StudentStudent | | | | | | | | | | | | | | | | | | | | CITY  EAST HARTFORD | | | | | | | | | | | | | | | | | | | | | STATE  CT | | | | | | | |
| ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | ZIP CODE  06118-0000 | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT’S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO  b. AUTO ACCIDENT? PLACE (State)  YES NO \_\_\_\_\_\_  c. OTHER ACCIDENT?  YES NO | | | | | | | | | | | | | | | | | | | | 11. INSURED’S POLICY GROUP OR FECA NUMBER  P40639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | a. INSURED’S DATE OF BIRTH | | | | | | | | | | | | | | | | | | | | SEX | | | | | | | | |
| MM  05 | | DD  03 | | | YY  1933 | | | | | | | | | | | | | | | M F | | | | | | | | |
| b. OTHER INSURED’S DATE OF BIRTH  MM DD YY | | | | | | | | | | | | | | | SEX | | | | | | | | | b. EMPLOYER’S NAME OR SCHOOL NAME  WALGREEN COMPANY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  | | | M F | | | | | | | | |
| c. EMPLOYER’S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | D. IS THERE ANOTHER HEALTH BENEFIT PLAN?  Yes  No ***If yes,*** return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | DATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: | | | | | | | | | | | ILLNESS (First symptom) OR | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| MM | | | DD | | YY | | | | | ← | INJURY (Accident) OR  PREGNANCY (LMP) | | | | | | | | | | | | | GIVE FIRST DATE | | | | | | | | | | | MM | | | | DD | | YY | | | FROM | | | MM | | | | DD | | | | YY | | | | TO | | | | | | MM | | | | DD | | YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | | | | | | | | | | 17a. |  | | |  | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 b | NPI | | |  | | | | | | | | | | | | | | | | FROM | | | | MM | | | DD | | | YY | | | | | | TO | | | | | MM | | | | DD | YY | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? $ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNES OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | 22. MEDICAID RESUBMISSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | 722.2 | | | | | |  | | | | | | | | | | | | | | 3. | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 2. |  | | | | | |  | | | | | | | | | | | | | 4. | | |  | | | | | | | |  | | | | | | | | | | | | |
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| 24. A. DATE(S) OF SERVICE  From To  MM DD YY MM DD YY | | | | | | | | | | | | | | B. PLACE  OF  SERVICE | | | C.  EMG | | | | | 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. # | | | | | |  | |
| CPT/HCPCS | | | | | MODIFIER | | | | | | | | | | | | |
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|  | | | | | |  | | | | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | |  | | | | | | | |  | | | | NPI | | | | |  | | | | | |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | | | | | | | | | 26. PATIENT’S ACCOUNT NO. | | | | | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT  (For govt. claims, see back)  YES  NO | | | | | | | | | | | 28. TOTAL CHARGE | | | | | | | | | | | | 29. AMOUNT PAID | | | | | | | | | | | 30.BALANCE DUE | | | | | |  |
| $206 | | | | | | | 70 | | | | |  | | | | | |  | | | | | $ | | | |  | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH #  AMERICAN HOMEPATIENT EAST PO BOX 827451  PHILADELPHIA, PA | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| a. | | | | | | | | | | | | | | b. | | | | | | | | | | | | | a. | | | | | | | | | | | | | | | | b. | | | | | | | | | | | | |

\* This is not an actual Form HCFA-1500/CMS-1500, but is a reasonable facsimile thereof created for informational purposes only