1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 434-66-2546A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Miller, Rose

3. PATIENT'S BIRTH DATE MM DD YY: 01 05 89 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Michaels, David

5. PATIENT'S ADDRESS (No., Street): 457 Honey Creek Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): 90 Edgefield Avenue

CITY: Lexington STATE: NC

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Lexington STATE: NC

ZIP CODE: 27292 TELEPHONE (Include Area Code): (734) 344-5673

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 27292 TELEPHONE (Include Area Code): (734) 634-4563

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 467856756

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 05 03 85 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State): NC

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [X] NO

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 [X] 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.

SIGNED Rose Miller DATE 05/11/16

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 David Michaels

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 05 11 16 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 02 10 09

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 08 02 16 TO 08 20 16

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Marcus Smith, MD

17a. 4366344

17b. NPI 9938519043

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 08 05 16 TO 08 10 16

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES: 520.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 9900386032

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 12 16	08 14 16	11		85645		1	450 00	2		NPI	8454562354
2 08 15 16	08 18 16	22		57636		2	120 00	1		NPI	34573463456
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 76-3954234 [X]

26. PATIENT'S ACCOUNT NO.: 3446345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 570 00

29. AMOUNT PAID: $ 570 00

30. BALANCE DUE: $ 0 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Grand Plains Community Hospital
60 Magnolia Drive
Lexington, NC

a. 7730597882 b.

33. BILLING PROVIDER INFO & PH # (734) 432-4436

Grand Plains Community Hospital
60 Magnolia Drive
Lexington, NC

a. 7730597882 b.