Access Medicare (Cuatro LLC)

HEALTH INSURANCE CLAIM FORM

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

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ID1-12345

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE: MM 01 DD 16 YY 09 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

5. PATIENT'S ADDRESS (No., Street): 1000 Main Street

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

7. INSURED'S ADDRESS (No., Street): 1000 Main Street

CITY: Dallas | STATE: TX

8. RESERVED FOR NUCC USE

CITY: Dallas | STATE: TX

ZIP CODE: 75202 | TELEPHONE (Include Area Code): (832) 555-9876

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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): CareCore National LLC (Aetna Radiology)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: GP1-67890

a. OTHER INSURED'S POLICY OR GROUP NUMBER: ID2-12345

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

a. INSURED'S DATE OF BIRTH: MM 01 DD 16 YY 09 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: GP2-67890

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 2015-06-20

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Memorial Hermann Imaging, 2900 Richmond Ave, Houston, TX, 77098

20. OUTSIDE LAB? [ ] YES [ ] NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. 9

A. S02.91XA | B. S06.899A | C. | D. | E. | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06	20	15	06	20	15	41		A8429	NH	A	1500 00	1		NPI	1992733492
2	06	20	15	06	20	15	41		A8425	NH	A	178 40	22.3		NPI	1992733492
3	06	20	15	06	20	15	41		A8422	NH	A	2 20	1		NPI	1992733492
4	06	20	15	06	20	15	41		A8424	NH	A	750 00	3		NPI	1992733492
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 65-4032840 | SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.: AD00003F2

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

28. TOTAL CHARGE: $ 2430 60

29. AMOUNT PAID: $ 5 00

30. Rsvd for NUCC Use

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

SIGNED: DATE:

32. SERVICE FACILITY LOCATION INFORMATION: Courtyards At Pasadena, 4848 Red Bluff Rd, Pasadena, Tx, 77503

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (713) 456-7890
Our Special Old Name
Billing provider address 1, Billing provider address 2
SP City, TX, 71234-1234

a. 1234567893 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION