1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (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): 888888888

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PARKER, LINDA D

3. PATIENT'S BIRTH DATE MM DD YY: 01 05 1962 SEX M [ ] F [✓]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PARKER, LINDA D

5. PATIENT'S ADDRESS (No., Street): 6842 VICTORY

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

7. INSURED'S ADDRESS (No., Street): 6842 VICTORY

CITY: SAN DIEGO STATE: CA

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

CITY: SAN DIEGO STATE: CA

ZIP CODE: 92111 TELEPHONE (Include Area Code): (619) 555-5555

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

ZIP CODE: 92111 TELEPHONE (Include Area Code): (619) 555-5555

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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] 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 [ ] 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: SIGNATURE ON FILE DATE: 10 21 2009

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. 466 0

3.

2.

4.

22. MEDICAID 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 12 01 2009		11	N	94150	59	1	30 00	1		NPI	2123456789
2 12 01 2009		11	N	94240	59	1	43 82	1		NPI	2123456789
3 12 01 2009		11	N	94375	59	1	41 49	1		NPI	2123456789
4 12 01 2009		11	N	94720	59	1	59 93	1		NPI	2123456789
5										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 888888888 SSN [ ] EIN [✓]

26. PATIENT'S ACCOUNT NO.: 02

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

28. TOTAL CHARGE: $ 175 24

29. AMOUNT PAID: $ 0000

30. BALANCE DUE: $ 175 24

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.)

DR ROB GONZO

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

DR ROB GONZO
1621 ENTERPRISE
SAN DIEGO, CA 92111

a. 2123456789 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Help