1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Humana
PO Box 14610
Lexington KY 40512-4610

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — X
1a. INSURED'S I.D. NUMBER: 890456732

2. PATIENT'S NAME: DOE, John
3. PATIENT'S BIRTH DATE: 06 15 1955 — SEX: M X F
4. INSURED'S NAME: DOE, John

5. PATIENT'S ADDRESS: 1234 Main Street
6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS: 1234 Main Street

CITY: Anywhere — STATE: CA
8. PATIENT STATUS: Single Married Other X
CITY: Anywhere — STATE: CA

ZIP CODE: 90210 — TELEPHONE: (987) 654-3210
Employed X Full-Time Student Part-Time Student
ZIP CODE: 90210 — TELEPHONE: (987) 654-3210

9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: AN905-678

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH: 06 15 1955 — SEX: M X F

b. OTHER INSURED'S DATE OF BIRTH — SEX: M F
b. AUTO ACCIDENT? YES X NO — PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME: Universal Studios

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: Humana

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: 01 21 2011

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM / TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM / TO

19. RESERVED FOR LOCAL USE: Op rpt attached
20. OUTSIDE LAB? X YES NO — $ CHARGES: 250 00 | 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)
1. 525 25
2. 785 6
3.
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 567890456

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 JO01 02 21 11	02 21 11	11		21248		1	6000 00	3		NPI	8934267812
2 02 21 11	02 21 11	11		21210	99 51 52	1	3000 00	1		NPI	8934267812
3 ZZInterim prosthesis JO01 02 21 11	02 21 11	11		21089		1	1200 00	1		NPI	8934267812
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 364246789 — SSN EIN: EIN X
26. PATIENT'S ACCOUNT NO.: 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO
28. TOTAL CHARGE: $ 10200 00
29. AMOUNT PAID: $ 0 00
30. BALANCE DUE: $ 10200 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.)
Olya Zahrebelny DDS
02 21 2011
SIGNED / DATE

32. SERVICE FACILITY LOCATION INFORMATION
Dr. Olya Zahrebelny
636 North Michigan Avenue 3500
Chicago, IL 60610
a. 8934267812
b.

33. BILLING PROVIDER INFO & PH #: (312) 657 3400
Dr. Olya Zahrebelny
636 North Michigan Avenue 3500
Chicago, IL 60610
a. 8934267812
b.

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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