

## HEALTH INSURANCE CLAIM FORM

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

PICA								PICA	
MEDICARE MEDICAID     (Medicaid#)  (Medicaid#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)  XDL123A45678								
2. PATIENT'S NAME (Last Name, Fred Holmes		nitial)	3. PATIENT'S BIRTH DA	(ID#) X (ID#) TE SEX  O MX F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Fred Holmes				
5. PATIENT'S ADDRESS (No., St	reet)		6. PATIENT RELATIONS	7. INSURED'S ADDRESS (No., Street)					
123 Main St		CTATE	Self X Spouse	Child Other	123 Main Str	eet		СТОТС	
Berkeley		CA	8. RESERVED FOR NUC	C USE	Berkeley			CA	
ZIPCODE	/ SSS \ SSS				The second secon			(Include Area Code) ) 5551212	
9. OTHER INSURED'S NAME (La	( 555 ) 555 st Name, First Name		10. IS PATIENT'S COND	TION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER			,	
					7900				
a. OTHER INSURED'S POLICY C	R GROUP NUMBER	3	a. EMPLOYMENT? (Cum	ent or Previous)  NO	a. INSURED'S DATE OF BIRTH  MM   DD   YY  M				
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)	1 1 1970 M X F b. OTHER CLAIM ID (Designated by NUCC)				
			YES X NO L						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?	XNO	c. INSURANCE PLAN NAME OR PROGRAM NAME 40				
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CODES (Des		d. IS THERE ANOTHER	R HEALTH E	BENEFIT PL	AN?	
					1 1			e items 9, 9a, and 9d.	
12 PATIENT'S OR AUTHORIZED	PERSON'S SIGNAT	TURE I authorize the		ner information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for				
to process this claim. I also required.		rnment benefits either	to myself or to the party who	accepts assignment	services described t	ælow.			
Signature on	file		DATE		SIGNED				
14. DATE OF CURRENT ILLNESS		NANCY (LMP) 15.	OTHER DATE MM	DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION OF TO MM   DD				
17. NAME OF REFERRING PROV	JAL. VIDER OR OTHER S						LATED TO	CURRENT SERVICES	
Dr Phil Strangelove	9	17b	NPI 177063803	30	FROM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORM	IATION (Designated I	by NUCC)			20. OUTSIDE LAB?	NO	\$ CI	HARGES	
21. DI AGNOSIS OR NATURE OF	ILLNESS OR INJUR	Y Relate A-L to servi	ice line below (24E)	D Ind.	22. RESUBMISSION CODE		DRIGINAL RE	EF. NO.	
N95.0	B. L	c. L		D	23. PRIOR AUTHORIZA	ATION NUM	MBEB		
E L	F. L.	G. L к I		H. L			Man San J. J		
24. A. DATE(S) OF SERVICE From T	B. PLACE OF		DURES, SERVICES, OR Sain Unusual Circumstances)		F.	G. DAYS E	H. I. PSDT ID. Plan QUAL	J. RENDERING	
MM DD YY MM D	The state of the s				\$ CHARGES	OR R UNITS I	Plan QUAL	PROVIDER ID. #	
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							NPI		
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		1		1	1 ! 1	1			
							NPI		
							NPI		
25. FEDERALTAX I.D. NUMBER 95-1234567		26. PATIENT'S A		CCEPT ASSIGNMENT? For govt claims, see back)	28. TOTAL CHARGE	00 ± 29. A	MOUNT PA	D 30. Rsvd.for NUCC Use	
31. SIGNATURE OF PHYSICIAN	OR SUPPLIER		CILITY LOCATION INFOR	YES NO MATION	\$ U. 33. BILLING PROVIDE	1 1 1 1	H# (51	0 ) 555-1212	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse			ove, 2900 Regent Stree	Dr Phil Strangelove, 2900 Regent Street, Berkeley CA 94705					
SIGNED	DATE	a.	b 1770	638030	a. NPI	b.	1770638	3030	
NUCC Instruction Manual		w.nucc.org	PLEASE PRI	NT OR TYPE	APPRO	OVED ON	/IB-0938-1	197 FORM 1500 (02-12	



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PICA									PIC	A T
1. MEDICARE MEDICA	Notes that the second	CHAMPVA	GROUP HEALTH PLAN	FECA BEKLUN		1a. INSURED'S I.D. NUI			(For Program in Iten	n 1)
(Medicare#) (Medicaio	(Member ID#)	)#) (10#) XDL123A45678				A Mintall on Insidical \				
2. PATIENT'S NAME (Last Nam Fred Holmes	e, riist Name, Middle Illiau)	3.	NAME OF THE PARTY	70 MX	SEX	Fred Holmes	ast Name	, First Name,	ivildale initial)	
5. PATIENT'S ADDRESS (No.,	Street)	6.	. PATIENT RELATIO		BURED	7. INSURED'S ADDRES		reet)		
123 Main St			Self X Spouse	Child	Other	123 Main Stre	eet			
Berkeley STATE CA			. RESERVED FOR N	UCC USE		And the second s			STAT	
ZIP CODE	TELEPHONE (Include Are					ZIP CODE		TELEPHONI	E (Indude Area Code)	
94704 (555) 5551212						94704 (555)5551212				
9. OTHER INSURED'S NAME (	Last Name, First Name, Midd	le Initial) 10	O. IS PATIENT'S CON	NDITION RELA	ATED TO:	11. INSURED'S POLICY	GROUP	OR FECA NU	JMBER	
						7900	n The Cale West III			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			. EMPLOYMENT? (O			a. INSURED'S DATE OF BIRTH  MM   DD   YY  1   1   1970 M X  F				
b. RESERVED FOR NUCC USE		b	AUTO ACCIDENT?		PLACE (State)					
			YES							
C. RESERVED FOR NUCCUSE		C.	c. OTHER ACCIDENT?				INSURANCE PLAN NAME OR PROGRAM NAME			
			YES X NO 40							
d. INSURANCE PLAN NAME O	H PHOGRAM NAME	10	0d. CLAIM CODES (I	Jesignated by	NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES X NO if yes, complete items 9, 9a, and 9d.				
	BACK OF FORM BEFORE					13. INSURED'S OR AUT				
to process this claim. I also re			release of any medical or other information necessary to myself or to the party who accepts assignment			payment of medical benefits to the undersigned physician or supplier for services described below.				ier for
SIGNED Signature o	n file									
		V/IMPA 45 OT	DATE			SIGNED_	LADIE TO	STATOOK INTO	LIDDENT COOLIDATI	ON
14. DATE OF CURRENT ILLNE	QUAL.	QUAL.	HER DATE	M   DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY				
17. NAME OF REFERRING PR		DE 17a.				18. HOSPITALIZATION MM , DD	DATES R	ELATED TO	CURRENT SERVICES	The same of the sa
Dr Phil Strangelov	17b. 1	NPI 17706380	030		FROM				YY	
19. ADDITIONAL CLAIM INFOR	MATION (Designated by NU	CC)				20. OUTSIDE LAB?	T	\$C	HARGES	
21. DIAGNOSIS OR NATURE C	EILLNESS OB INJURY Bel	ate A-L to service	line below (24F)		!	22. RESUBMISSION	NO			
N95.0	- 1	0		ICD Ind.	1	CODE	1	ORIGINAL R	EF, NO.	
EL	F. L	G. L		D. L		23. PRIOR AUTHORIZA	TION NU	MBER		
ı. L	J. [	к. L		L. L						
24. A. DATE(S) OF SERVI From	To PLACE OF	(Explain	URES, SERVICES, OF Unusual Circumstanc		E. DIAGNOSIS	F.	G. DAYS OR	H. I. EPSOT ID. Family QUAL	J. RENDERIN	G
MM DD YY MM	DD YY SERVICE EM	G CPT/HCPCS	S   MOD	IFIER	POINTER	\$ CHARGES	UNITS	Plan QUAL	PROVIDER II	D. #
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								NPI		
				1 1				NPI		
25. FEDERALTAX I.D. NUMBE	R SSN EIN 26	6. PATIENT'S ACC	COUNT NO. 2	7. ACCEPT AS	SSIGNMENT?	28. TOTAL CHARGE	29.	AMOUNT PA	ID 30. Rsvd.for f	NUCC Use
95-1234567	<u>×</u> 0	3+12345		X YES	NO	\$ 0.0	00 \$			
31. SIGNATURE OF PHYSICIA INCLUDING DEGREES OR	The state of the s	2. SERVICE FACIL	LITY LOCATION INF	ORMATION		33. BILLING PROVIDER	INFO&	₽₩# (51	0 ) 555-1212	10 A
(I certify that the statements on the reverse			e, 2900 Regent Str	eet, Berkele	y CA 94705	Dr Phil Strangelove, 2900 Regent Street, Berkeley CA 94705				5
Dr Phil Strangelove										
SIGNED	DATE a.	NP	b. 177	0638030	)	a. NP	b.	177063	8030	
NUCC Instruction Manua	Philippedian in the	icc.org	PLEASE P	RINT OR T	TYPE	APPRO	VED O	MB-0938-	1197 FORM 1500	) (02-12



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MEDICARE MEDICAR     (Medicare#) (Medicaida		OPVA GROUP HEALTH PLAN (ID#)	FECA OTHER BLK LUNG (ID#)	1a. INSURED'S I.D. NUMBER XDL123A45678	(For Program i	n Item 1)	
2. PATIENT'S NAME (Last Name Fred Holmes	e, First Name, Middle Initial)	3. PATIENT'S BIRTH DAT		4. INSURED'S NAME (Last Name Fred Holmes	e, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., S 123 Main St	treet)	6. PATIENT RELATIONSH Self X Spouse	TIP TO INSURED  Child Other	7. INSURED'S ADDRESS (No., 8 123 Main Street	Street)		
CITY Berkeley	ST A		CUSE	Berkeley	STATE		
ZIPCODE	TELEPHONE (Include Area Code)			ZIP CODE	TELEPHONE (Include Area C	Code)	
94704	(555) 5551212			94704	2		
9. OTHER INSURED'S NAME (L	ast Name, First Name, Middle Initial)	10. IS PATIENT'S CONDIT	TION RELATED TO:	11. INSURED'S POLICY GROUP 7900	OR FECA NUMBER		
a. OTHER INSURED'S POLICY	OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BIRTH  MM   DD   YY  1   1   1970			F	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (Designate			
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME			
		YES	X NO	40			
d. INSURANCE PLAN NAME OF	R PROGRAM NAME	10d. CLAIM CODES (Designation	gnated by NUCC)	d. IS THERE ANOTHER HEALTH			
12. PATIENT'S OR AUTHORIZED to process this claim. I also red below.	BACK OF FORM BEFORE COMPLETO PERSON'S SIGNATURE I authorize quest payment of government benefits ei	the release of any medical or other		13. INSURED'S OR AUTHORIZE	if yes, complete items 9, 9a, and D PERSON'S SIGNATURE I and the undersigned physician or	uthorize	
Signature or	1 1110	DATE		SIGNED_			
MM   DD   YY	SS, INJURY, or PREGNANCY (LMP)	QUAL. MM	DD   YY	16. DATES PATIENT UNABLE T	O WORK IN CURRENT OCCU MM   DD   TO	PATION YY	
17. NAME OF REFERRING PRO	Scott and the second file ages of the second second	17a. NPI 1770638030	<u></u>	18. HOSPITALIZATION DATES F MM DD Y	RELATED TO CURRENT SERV	/ICES YY	
19. ADDITIONAL CLAIM INFOR		111003003	0	20. OUTSIDE LAB?	\$ CHARGES		
21 DIAGNOSIS OR NATURE OF	FILLNESS OR INJURY Relate A-L to	service line below (24E)		YES X NO 22. RESUBMISSION			
N95.0		ICD	Ind.	CODE	ORIGINAL REF. NO.		
A [1400.0	B. L	3	D	23. PRIOR AUTHORIZATION NU	JMBER		
	T. L.	a	H				
24. A. DATE(S) OF SERVICE From MM DD YY MM I	TO PLACE OF (E	OCEDURES, SERVICES, OR SU Explain Unusual Circumstances) HCPCS   MODIFIE	DIAGNOSIS	F. G. DAYS OR UNITS	Traffill (	J. ERING DERID.#	
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25. FEDERALTAX I.D. NUMBER	R SSN EIN 26, PATIEN	r'S ACCOUNT NO. 27. A	CCEPT ASSIGNMENT?	28. TOTAL CHARGE 29	MPI 30. Rsw	d for NUCC Use	
95-1234567	× 03+123	<i>1</i>	CCEPT ASSIGNMENT? or govt claims, see back) YES NO	\$ 0.00			
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR (I certify that the statements of applications this bill applications and the statements of applications are applications and the statements of applications and the statements of applications and the statements of applications are applications and the statements of applications and the statements of applications and the statements of applications are applications and the statements are applications	CREDENTIALS on the reverse	E FACILITY LOCATION INFORM		33. BILLING PROVIDER INFO &	(0.0)		
apply to this bill and are made Dr Phil Strangelove	Dr Phil Stra	nglove, 2900 Regent Street	, Berkeley CA 94705	Dr Phil Strangelove, 2900 Re	egent Street, Berkeley CA 9	94705	
SIGNED	DATE a.		38030	a. 1770638030			
VIII CO Instruction Manual	available at: www.pucc.org	DIFACE DRII	UT AD TVDE	APPROVED C	WB-0938-1197 FORM	1500 (02-1	