HEALTH INSURANCE CLAIM FORM

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

PICA

STATE FARM - NF
PO BOX 106170,
ATLANTA, GA 30348-6170

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	CL# 3249F002R
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MANTILLA, DORA	3. PATIENT'S BIRTH DATE MM DD YY: 06 17 1959 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial) MANTILLA, DORA	
5. PATIENT'S ADDRESS (No., Street) 259 BROADWAY	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street) 259 BROADWAY	
CITY: HUNTINGTON — STATE: NY	8. RESERVED FOR NUCC USE
CITY: HUNTINGTON — STATE: NY	
ZIP CODE: 11743 — TELEPHONE (Include Area Code): (631) 965-9610	
ZIP CODE: 11743 — TELEPHONE (Include Area Code): (631) 965-9610	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) MANTILLA, DORA	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER 3213907A0332	
a. OTHER INSURED'S POLICY OR GROUP NUMBER STATE FARM - NF	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY: 06 17 1959 SEX: M [ ] F [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State): NY
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM - NF	
d. INSURANCE PLAN NAME OR PROGRAM NAME ATTORNEY: THWAITES STATEFARM_OL	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 06/27/24

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. 439 MM DD YY: 05 02 23	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) TEDDY JEAN CALIXTE PA NPI 1639481112		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M5417 B. M5126 C. M5412 D. M7918 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 03 13 24 / 03 13 24	11		99214	25	ABC	127 41	1		NPI	1639481112
2 03 13 24 / 03 13 24	11		20552		D	118 41	1		NPI	1639481112
3 03 13 24 / 03 13 24	11		76942	59	D	298 03	1		NPI	1639481112
4 DEXAMETHASONE 03 13 24 / 03 13 24	11		99070		D	44 00	1		NPI	1639481112
5 BUPIVICAINE 03 13 24 / 03 13 24	11		99070		D	44 00	1		NPI	1639481112
6 LIDOCAINE 03 13 24 / 03 13 24	11		99070		D	36 00	1		NPI	1639481112

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
113558267 [ ] [X]	53648623656	[X] YES [ ] NO	$ 667 85	$ 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201) 857-4011
Signature on File TEDDY J CALIXTE, PA SIGNED 06/27/24 DATE	PHOENIX MEDICAL SERVICES PC 1800A NEW YORK AVE HUNTINGTON STATION, NY 11746-0000 a. 1245450857 b.	PHOENIX MEDICAL SERVICES PC PO BOX 9415 NEW YORK, NY 10087-9415 a. 1245450857 b.