# 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: 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: 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 05 DD 02 YY 23 |
| 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. 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<br>A. M7918 B. M5417 C. M5126 D. M5412<br>E. F. G. H.<br>I. J. K. L. | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER |

PHYSICIAN OR SUPPLIER INFORMATION

| 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 STERILE NEEDLE<br>03 13 24 03 13 24 | 11 | | 99070 | | A | 20 00 | 1 | | NPI | 1639481112 |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

| 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 | $ 20 00 | $ 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<br>TEDDY J CALIXTE, PA<br>SIGNED 06/27/24 DATE | PHOENIX MEDICAL SERVICES PC<br>1800A NEW YORK AVE<br>HUNTINGTON STATION, NY 11746-0000<br>a. 1245450857 b. | PHOENIX MEDICAL SERVICES PC<br>PO BOX 9415<br>NEW YORK, NY 10087-9415<br>a. 1245450857 b. |