File Received Date : 01/22/2019
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Is Eligible : No

HEALTH INSURANCE CLAIM FORM

Claim ID : OA1899991111

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

PICA

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ABCDE1111449

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, New w.

3. PATIENT'S BIRTH DATE MM DD YY: 02 17 94 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Patient, New w.

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

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

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

CITY: City STATE: St

8. RESERVED FOR NUCC USE

CITY: City STATE: st

ZIP CODE: 35000 TELEPHONE (Include Area Code): (530) 333-2211

ZIP CODE: 35000 TELEPHONE (Include Area Code): (530) 333-2211

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Last, Other First Middle.

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 276111A777

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 6546546549

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

a. INSURED'S DATE OF BIRTH MM DD YY: 02 17 94 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE: 03 23 54

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

b. OTHER CLAIM ID (Designated by NUCC): Employer School Name

c. RESERVED FOR NUCC USE: Employer School Name

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Insurance Plan Name

d. INSURANCE PLAN NAME OR PROGRAM NAME: Insurance Plan Name

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] 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 IS ON FILE DATE 02/01/2019

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 IS ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 28 19 QUAL.

15. OTHER DATE QUAL. MM DD YY: 01 31 19

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 02 13 19 TO 02 10 19

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SourceName

17a. LOR6546546547

17b. NPI 4214214210

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 02 03 19 TO 02 06 19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 1925.0

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. M79675 B. M25775 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: Code1234 ORIGINAL REF. NO.: 1236547899

23. PRIOR AUTHORIZATION NUMBER

Total Allowed Amount : $0.00

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. #
						Allowed :	***$0.00***				SAMPLE LAURA
1 02 20 19	02 25 19	30	emr	S0020	AL	1	$14.00	2		NPI	12345
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 [X]

26. PATIENT'S ACCOUNT NO.: 00062779

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

28. TOTAL CHARGE: $ $95.00

29. AMOUNT PAID: $ $35.00

30. Rsvd for NUCC Use: $60.00

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.)

SIGNATURE IS ON FILE

SIGNED 02/04/2019

32. SERVICE FACILITY LOCATION INFORMATION

BACK TTD PODIATRY
23498 MAGDALENA 123
LAGUNA HILLS, CA

a. 3213213210 b. 5215215210

33. BILLING PROVIDER INFO & PH # (949) 499-4534

BACK TTTS PODIATRY
23456 MAGDALENA 123
LAGUNA HILLS, CA

a. 3213213210 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE LAURA