1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Name and Address of the Insurance Company goes here.

CARRIER

PICA ☐ PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☒ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN A.

3. PATIENT'S BIRTH DATE MM DD YY: 11 08 51 — SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, SALLY M.

5. PATIENT'S ADDRESS (No., Street): 1234 Main STREET

CITY: Anywhere — STATE: NY

ZIP CODE: 11234 — TELEPHONE (Include Area Code): (315) 222-3333

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 1234 Main St.

CITY: Anywhere — STATE: NY

ZIP CODE: 11234 — TELEPHONE (Include Area Code): (315) 222-3333

8. PATIENT STATUS: Single ☐ Married ☒ Other ☐ — Employed ☒ Full-Time Student ☐ Part-Time Student ☐

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

c. OTHER ACCIDENT? ☒ YES ☐ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: H8374521 X

a. INSURED'S DATE OF BIRTH MM DD YY: 05 10 53 — SEX M ☐ F ☒

b. EMPLOYER'S NAME OR SCHOOL NAME: ANYWHERE DAILY NEWS

c. INSURANCE PLAN NAME OR PROGRAM NAME

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: 9/1/2006

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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — MM DD YY: 09 01 06

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Mark Smith

17a.

17b. NPI: Dr. M. SMITH NPI #

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 848.3
2. 354.9
3. 719.59
4. .

22. MEDICAID 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	09 05 06	09 05 06	11		99202		1-3	75 00	1		NPI	YOUR NPI GOES HERE
2	09 05 06	09 05 06	11		97810		1-3	45 00	1		NPI	NPI #
3	09 05 06	09 05 06	11		97811		1-3	45 00	1		NPI	NPI #
4	09 05 06	09 05 06	11		97124		1-3	25 00	1		NPI	NPI #
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 84-1234567 — SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 190 00

29. AMOUNT PAID: $ Ø

30. BALANCE DUE: $ 190 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.)

Sally Jones, L.Ac

SIGNED — DATE: 9/5/06

32. SERVICE FACILITY LOCATION INFORMATION

ABC Acupuncture Clinic
1111 Broadway
ANYWHERE NY 11235

a. b.

33. BILLING PROVIDER INFO & PH #: (315) 211-1222

SALLY JONES, L.Ac.
1111 Broadway
ANYWHERE NY 11235

a. b.

Your NPI # GOES HERE

NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING