HEALTH INSURANCE CLAIM FORM

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

	PICA									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#)	✔ (ID#)	111223333	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ANDRETTI, RON

3. PATIENT'S BIRTH DATE — MM 09 | DD 13 | YY 1976 — **SEX** M ✔ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ANDRETTTI, RON

5. PATIENT'S ADDRESS (No., Street)
1633 CIRCLE PLACE

6. PATIENT RELATIONSHIP TO INSURED
Self ✔ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)
1633 CIRCLE PLACE

CITY CORVALLIS — **STATE** OR

8. RESERVED FOR NUCC USE

CITY CORVALLIS — **STATE** OR

ZIP CODE 97333 — **TELEPHONE (Include Area Code)** (541) 7582551

ZIP CODE 97333 — **TELEPHONE (Include Area Code)** (541) 7582551

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
69932145

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH — MM 09 | DD 13 | YY 1976 — **SEX** M ✔ F ☐

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ✔

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
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 TODAY'S DATE

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) — MM TOD | DD AYS | YY DATE — QUAL.

15. OTHER DATE — QUAL. — 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 — 17a. — 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — **ICD Ind.** 9

- A. 7242
- B.
- C.
- D.
- 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	TOD AYS DATE TOD AYS DATE	11		99395		A	300 00	1		NPI	LKK32669
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 542669889 — **SSN EIN** ✔

26. PATIENT'S ACCOUNT NO. 2345

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

28. TOTAL CHARGE $ 300 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)
ACTUAL SIGNATURE

SIGNED — DATE TOMORROW

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI — b.

33. BILLING PROVIDER INFO & PH # (541) 7539969
JAMES SHERMAN DO
5562 CASPIAN WAY
CORVALLIS OR 97330
a. NPI — b.

NUCC Instruction Manual available at: www.nucc.org — **PLEASE PRINT OR TYPE** — APPROVED OMB-0938-1197 FORM 1500 (02-12)