HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 222334444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ANDRETTI, PATTY, P

3. PATIENT'S BIRTH DATE MM DD YY: 11 13 1976 SEX M [ ] F [✔]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ANDRETTI, PATTY P

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: 67032145

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 11 13 1976 SEX M [ ] F [✔]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [✔] NO [ ] PLACE (State): OR

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [✔]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE

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 DD YY: TODAYS DATE QUAL.

15. OTHER DATE QUAL. MM DD YY

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)

20. OUTSIDE LAB? YES [ ] NO [✔] $ CHARGES

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

A. 7242 B. C. D. 9

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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 TOD AYS DATE	TOD AYS DATE	11		99395		A	412 00	1		NPI	LKK32669
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [✔] EIN [ ]: 542669889

26. PATIENT'S ACCOUNT NO.: 5674

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

28. TOTAL CHARGE: $ 412 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 TMORROW

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.