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): 666778888

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TORRES, ALEXANDER

3. PATIENT'S BIRTH DATE MM DD YY: 06 07 1968 SEX M [✔] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): TORRES, ALEXANDER

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

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

7. INSURED'S ADDRESS (No., Street): 456 PONDEROSA PINE COURT

CITY: | STATE:

8. RESERVED FOR NUCC USE

CITY: ALBANY | STATE: OR

ZIP CODE: | TELEPHONE (Include Area Code): ( )

ZIP CODE: 97321 | TELEPHONE (Include Area Code): (541) 2223333

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 7890456 WS123

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

a. INSURED'S DATE OF BIRTH MM DD YY SEX: 06 07 1968 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: USNC/AD

d. INSURANCE PLAN NAME OR PROGRAM NAME: ODS

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 SOF 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 SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 01 2014 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: SEYMOUR KOFFS DO

17a.

17b. NPI 2313890

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. 0

A. Z0000 B. C. D.

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	06 03 14		06 03 14			11		99205		A	150 00	1		NPI	2313890
2	06 03 14		06 03 14			11		94640		A	40 00	1		NPI	2313890
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 4217890908 [ ] [✔]

26. PATIENT'S ACCOUNT NO.: 52556

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

28. TOTAL CHARGE: $ 190 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.)

SOF

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ACUMEN MEDICAL PRACTICE
791 NORTH LANE
SOMEWHERE OR 12345

a. X100X1000 b.

33. BILLING PROVIDER INFO & PH # (555) 8888888

ACUMEN MEDICAL PRACTICE
791 NORTH LANE
SOMEWHERE OR 12345

a. X100X1000 b.