

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	2			1
PICA		I	PICA	Д₹
1. MEDICARE MEDICAID TRICARE CHAMP		1a. INSURED'S I.D. NUMBER	(For Program in Item 1)	
(Medicare#) (Medicaid#) (ID#/DoD#) (Member		4 Bioupepio Marie (C. 18)	E AN ARTHUR DE B	41
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Nam	e, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., S	Street	-11
5. FATIENT S ADDRESS (No., Street)		7. INSURED S ADDRESS (No., s	Street)	
OTATI	Self Spouse Child Other	OLTY	OTATE	-
CITY	8. RESERVED FOR NUCC USE	CITY	STATE	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)	INFORMATION
/ \		ZIF CODE	/ \	2
O OTHER INCURER ON AMERICAN AND AN ARCHITECTURE.	40 IO DATIFATIO CONDITION DEL ATER TO	11, INSURED'S POLICY GROUP	OD SECON NUMBER	S
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	TT. INSURED S POLICY GROUP	OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX	_ _ [
a. OTHER INCOMED ST CLICT CIT GROOT NOWIDER	YES NO	MM DD YY	M F	
b. RESERVED FOR NUCC USE	h AUTO ACCIDENT?	b. OTHER CLAIM ID (Designate		⊣ ≧
	PLACE (State)	b. OTHER CLAIM ID (Designate	d by NOCC)	QN V
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OF	R PROGRAM NAME	٦٢-
O. NEGENVED I OTTNOGG GGE	YES NO	O. INCOMANGE PLAIN INMINE OF	TE HOURAWI NAME	ATIENT
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALT	H RENEEIT PLAN?	- Ę
U. INSURANCE FEAN NAME OF FROGRAM NAME	Tod. CLAIM CODES (Designated by NOCC)			١٩
READ BACK OF FORM BEFORE COMPLETIN	IC & SIGNING THIS FORM		If yes, complete items 9, 9a, and 9d. ED PERSON'S SIGNATURE I authorize	\dashv
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the to process this claim. I also request payment of government benefits either the process that the process the process that the process the process that the process	e release of any medical or other information necessary	payment of medical benefits t	to the undersigned physician or supplier for	
to process this claim. I also request payment or government benefits either below.	r to myself or to the party who accepts assignment	services described below.		
SIGNED	DATE	SIGNED		
	OTHER DATE		O WORK IN CURRENT OCCUPATION	= ;
MM DD QUAL.	JAL. MM DD YY	FROM I	O WORK IN CURRENT OCCUPATION Y MM DD YY TO I	_ 1
	'a.		RELATED TO CURRENT SERVICES Y MM DD YY	\dashv
	b. NPL	. MM DD Y FROM I	Y MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$ CHARGES	$\exists 1$
	•	YES NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	vice line below (24E)	22. RESUBMISSION CODE		\dashv
A. L. B. C.		CODE	ORIGINAL REF. NO.	
A. B. C. E. G.	23. PRIOR AUTHORIZATION N	JMBER	$\exists 1$	
7. L				
24. A. DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E.	F. G. DAYS	H. I. J. EPSDT ID BENDERING	Ⅎᡓ
From	lain Unusual Circumstances) DIAGNOSIS PCS MODIFIER POINTER	\$ CHARGES UNITS	Family ID. RENDERING Plan QUAL. PROVIDER ID. #	F
			NPI	78
				NOTAMOCENI
			NPI	0
			NPI	
			NPI	_ 2
			NPI	_ {
			,	_ Š
			NPI	Щ.
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29	. AMOUNT PAID 30. Rsvd for NUCC U	se
	YES NO	\$		_
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE F	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO &	PH # ()	
(I certify that the statements on the reverse				
apply to this bill and are made a part thereof.)				
				4
SIGNED DATE a.	b.	a. NPI b.		1

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an Informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

<u>DISCLOSURES</u>: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is ostimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

(20) (4(E))				
HEALTH INSURANCE CLAIM FO	ORM			ARRIER
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE				
PICA				PICA PICA
1. MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP DAN FECA OTHER 1	1a. INSUFED'S I.D. NUMBER	(For Program in Lern 1)
(Medicare#) (Medicaid#) (ID#/DoD#)	(Member ID#)	(ID#) (ID#)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. P	PATIENT'S EIRTH DATE SEX	4. INSURED'S NAME (Last Name, F	rst Name, Micdle Initial)
		MF		
5 PATIENT'S ADDRIESS (No., Street)			7. INSURED'S ADDRESS (No., Stre	(t)
		Self Spouse Child Other Description		
CITY	STATE 8. R	RESERVED FOR NUCC USE	CITY	STATE Z
ZIP CODE TELEPHONE (Include An	rea Code)		ZIP ÇODE TI	LEPHONE (Include Area Code)
				
9. OTHER INSURED'S NAME (Last Name, First Name, Midd	dle nitial) 10. I	IS PATIENT'S CONDITION RELATED TO: 1	11. INSUFED'S POLICY GROUP OF	STATE
				
a OTHER INSURED'S POLICY OR GROUP NUMBER	a. E		a. INSURED'S DATE OF BIRTH	SEX
		YES NC		NUCE) SEX BY SEX NUCE) OF THE SEX SEX SEX SEX SEX SEX SEX SEX SEX SE
b RESERVED FOR NUCC USE	b. A		o. OTHER CLAIM ID (Designated by	NUCC)
		YES NO NO		
c. RESERVED FOR NUCC USE		OTHER ACCIDENT?	C. INSURANCE PLAIN NAME OR PE	DGRAM NAME H
d, INSURANCE FLAN NAME OR PROGRAM NAME	104		d. IS THERE ANOTHER HEALTH BI	NEFIT PLAN?
	+++++			s, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE	E COMPLETING & SI	SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED F	
to process this claim. I also request payment of governmen		se of any medical or other information necessary yself or to the party who accepts assignment	payment of medical penelits to the services described below.	undersigned physician or supplier for
below.				
\$IGNED		DATE	SIGNED	<u> </u>
14. DATE OF CURRENT ILLNESS, NJURY of PREGNANC	OY (LNIP) 15. OTHE	ER DATE MM DD YY	16. DATES PATIENT UNABLE TO V	MMI DDI YY 11
QUAL.	QUAL.		FROM	ТО
17 NAME OF REFERRING PROVIDER OR OTHER SOUR	↑E 170		18 HOSPITALIZATION DATES BEL	ATED TO CURRENT SERVICES
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			18. HOSPITALIZATION DATES REL	ATED TO CURRENT SERVICES
	17b. NP	PI	FROM	ТО
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. ADDITIONAL CLAIM INFORMATION (Designated by NU.)	17b. NP	PI	FROM 1 20. OUTSIDE LAB?	ATED TO GURRENT SERVICES TO S CHARGES
	17b. NP	2	FROM	ТО
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU	17b. NP	2	FROM 1 20. OUTSIDE LAB?	ТО
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU	17b. NP	ind below (24E) ICD Inst. 2	FROM	S CHARGES
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. F. F. J.	JCC) Blate A-L to service In C. G. K.	ne below (24E) ICD Inst. 2	FRØM 2C. QUTSIDE LAE? 22. FESUBMISSIÓN CODE 22. FRIOFI AUTHORIZATION NUME	S CHARGES IGNAL REF. NO.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. F. F. L. L. L. DATE(S) OF SERVICE B. C. B. C.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGNAL REF. NO.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. F. F. J.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Inst. 2	FRØM 2C. QUTSIDE LAE? 22. FESUBMISSIÓN CODE 22. FRIOFI AUTHORIZATION NUME	S CHARGES IGNAL REF. NO.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. F. F. I. 24. A. DATE(S) OF SERVICE B. C.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	SCHARGES IGNAL REF. NO. EFF II RENDERING OF THE PROVICER ID. # H. W.
19. ADDITIONAL CLAIM INFORMATION Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. F.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	SCHARGES IGNAL REF. NO. EFF II RENDERING OF THE PROVICER ID. # H. W.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. F. F. I. 24. A. DATE(S) OF SERVICE B. C.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES RIGINAL REF. NO. EF III RENDERING PROVIDER ID. # HE CHARGES NPI U. RENDERING PROVIDER ID. # HE CHARGES
19. ADDITIONAL CLAIM INFORMATION Designates by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. F. I. J.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGINAL REF. NO. EF OT I. FRENDERINS PROVIDER ID. # WW. NPI UO NPI
19. ADDITIONAL CLAIM INFORMATION Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. F.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGINAL REF. NO. EF OT I. FRENDERINS PROVIDER ID. # WW. NPI U. NPI
19. ADDITIONAL CLAIM INFORMATION Designates by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. F. I. J.	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGINAL REF. NO. EF OT I. FRENDERINS PROVIDER ID. # WW. NPI U. NPI
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. 1. 24. A. DATE(S) OF SERVICE MIM DD YY MM DD YY SERVICE EMIC	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGINAL REF. NO. EF OUAL. PROVIDER ID. # H. W.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. 1. 24. A. DATE'S OF SERVICE MM DD YY MM DD YY SERVICE EM 1. 24. A. DATE'S OF SERVICE 25. C. SERVICE EM 1. 26. A. DATE'S OF SERVICE 27. AMM DD YY SERVICE EM 28. C. SERVICE EM 19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 10. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. 4. A. DATE'S OF SERVICE 26. ADDITIONAL CLAIM INFORMATION 'Designated by NU 27. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY RE R. 4. A. DATE'S OF SERVICE 28. ADDITIONAL CLAIM INFORMATION 'Designated by NU 29. ADDITIONAL CLAIM INFORMATION 'Designated by NU 40. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY RE R. 4. A. DATE'S OF SERVICE 29. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 20. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 20. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 21. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 22. ADDITIONAL CLAIM INFORMATION 'DESIGNATION 'DESIGN	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGINAL REF. NO. EF OUAL. PROVIDER ID. # H. W.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. 1. 24. A. DATE(S) OF SERVICE MIM DD YY MM DD YY SERVICE EMIC	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGINAL REF. NO. EF OUAL. PROVIDER ID. # H. W.
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. 1. 24. A. DATE'S OF SERVICE MM DD YY MM DD YY SERVICE EM 1. 24. A. DATE'S OF SERVICE 25. C. SERVICE EM 1. 26. A. DATE'S OF SERVICE 27. AMM DD YY SERVICE EM 28. C. SERVICE EM 19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 10. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. 4. A. DATE'S OF SERVICE 26. ADDITIONAL CLAIM INFORMATION 'Designated by NU 27. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY RE R. 4. A. DATE'S OF SERVICE 28. ADDITIONAL CLAIM INFORMATION 'Designated by NU 29. ADDITIONAL CLAIM INFORMATION 'Designated by NU 40. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY RE R. 4. A. DATE'S OF SERVICE 29. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 20. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 20. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 21. ADDITIONAL CLAIM INFORMATION 'DESIgnated by NU 22. ADDITIONAL CLAIM INFORMATION 'DESIGNATION 'DESIGN	alate A-L to service In C. G. K. D. PROCEDURE	ne below (24E) ICD Ins. 2 D 2 RES, SERVICES, OR SUPPLIES 5.	FROM 2C. OUTSIDE LAE? 22. FESUBMISSION CODE 23. FRIOR AUTHORIZATION NUMBER F. DAYS FROM DAYS FROM PROM PRO	S CHARGES IGNAL REF. NO. EF IONAL PEF. NO. PENDERING PHOVICER ID. # NPI NPI NPI NPI NPI NPI NPI NP
19. ADDITIONAL CLAIM INFORMATION (Designate Lity NU. 21. DIAGNOSIS OR NATURE OF ILL NESS OF INJURY Re A. E. F. 14. A. DATE'S OF SERVICE MIM DD YY MM DD YY SERVICE EMM 1	ITAD. NP JCC) Slate A-L to service in C. G. K. D. PROCEDURE (Explain on G. CPT/HCPCS	PI 2 Inc below (24E) ICD Ins. 2 RES, SERVICES, OR SUPPLIES E. MODIFIER POINTER POINTER	FROM 2C. OUTS DE LAB? 22. FESUBMISSION CODE F. GS S CHARGES S CHARGES OR FRI FRI FRI FRI FRI FRI FRI	SCHARGES IGNAL REF. NO. EF OUAL. PROVIDER ID. # HE PROVIDER ID
19. ADDITIONAL CLAIM INFORMATION (Designate Lity NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. 24. A. DATE'S OF SERVICE NIM DD YY MM DD YY SERVICE EMM 1 2 3 4 5 6	alate A-L to service In C. G. K. D. PROCEDURE	ind below (24E) ICD Ind. 2 RES. SERVICES, OR SUPPLIES E. musual Circumstances) MODIFIER POINTER DIAGNOSIS DIAGNOSIS POINTER DIAGNOSIS D	FROM 2C. OUTS DE LAB? 22. FESUBMISSION CODE F. GS S CHARGES S CHARGES OR FRI FRI FRI FRI FRI FRI FRI	S CHARGES IGNAL REF. NO. EF
19. ADDITIONAL CLAIM INFORMATION (Designate Lity NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. F.	JCC) Slate A-L to service In C. G. K. D. PROCEDURE (Explain'th G. CPT/HCPCS	ind below (24E) ICD Ind. 2 RES. SERVICES, OR SUPPLIES E. musual Circums ances) MODIFIER POINTER DUNT NO. 27. ACCERT, ASSIGNMENT? 2 YES NC	FROM 2C. OUTS DE LAB? 22. FESUBMISSIÓN CODE F. G.S. FRIOR AUTHORIZATION NUMB F. G. FRIOR	S CHARGES IGNAL REF. NO. EF
19. ADDITIONAL CLAIM INFORMATION (Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. P. 1. 24. A. DATE'S OF SERVICE INIM DD YY MM DD YY SERVICE EMM 1 1 2 1 3 4 5 6 25. FEDERAL TAX LD. NUMBER SSN EN 20 1 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32 1 1 1 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	JCC) Slate A-L to service In C. G. K. D. PROCEDURE (Explain'th G. CPT/HCPCS	ind below (24E) ICD Ind. 2 RES. SERVICES, OR SUPPLIES E. musual Circums ances) MODIFIER POINTER DUNT NO. 27. ACCERT, ASSIGNMENT? 2 YES NC	FROM	S CHARGES IGNAL REF. NO. EF
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. F. I. 24. A. DATE'S OF SERVICE RACE OF INJURY RE MM DD YY MM DD YY SERVICE EM 1	JCC) Slate A-L to service In C. G. K. D. PROCEDURE (Explain'th G. CPT/HCPCS	ind below (24E) ICD Ind. 2 RES. SERVICES, OR SUPPLIES E. musual Circums ances) MODIFIER POINTER DUNT NO. 27. ACCERT, ASSIGNMENT? 2 YES NC	FROM	S CHARGES IGNAL REF. NO. EF
19. ADDITIONAL CLAIM INFORMATION (Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re A. E. P. 1. 24. A. DATE'S OF SERVICE INIM DD YY MM DD YY SERVICE EMM 1 1 2 1 3 4 5 6 25. FEDERAL TAX LD. NUMBER SSN EN 20 1 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32 1 1 1 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	JCC) Slate A-L to service In C. G. K. D. PROCEDURE (Explain'th G. CPT/HCPCS	PI	FROM 2C. OUTS DE LAB? 22. FESUBMISSIÓN 23. FRIOFI AUTHORIZATION NUME F	S CHARGES IGNAL REF. NO. EF
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. F. J.	ITAD. NP JCC) Blate A-L to service In C. G. K. ID. PROCEDURE G. CPT/HCPCS CPT/HCPCS 26. PATIENT'S ACCO 32. SERVICE FAGIL T	PI	FROM 2C. OUTS DE LAB? 22. FESUBMISSIÓN 23. FRIOFI AUTHORIZATION NUME F	SCHARGES IGNAL REF. NO. EF NPI NPI NPI NPI NPI NPI NPI NP
19. ADDITIONAL CLAIM INFORMATION (Designated by NU 21. DIAGNOSIS OR NATURE OF ILL NESS OF INJURY Re R. F. J.	ITAD. NP JCC) Blate A-L to service In C. G. K. ID. PROCEDURE G. CPT/HCPCS CPT/HCPCS 26. PATIENT'S ACCO 32. SERVICE FAGIL T	PI	FROM 2C. OUTS DE LAB? 22. FESUBMISSIÓN 23. FRIOFI AUTHORIZATION NUME F	S CHARGES IGNAL REF. NO. EF
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. F. J.	ITAD. NP JCC) Blate A-L to service In C. G. K. ID. PROCEDURE G. CPT/HCPCS CPT/HCPCS 26. PATIENT'S ACCO 32. SERVICE FAGIL T	PI	FROM 2C. OUTS DE LAB? 22. FESUBMISSIÓN 23. FRIOFI AUTHORIZATION NUME F	SCHARGES IGNAL REF. NO. EF NPI NPI NPI NPI NPI NPI NPI NP
19. ADDITIONAL CLAIM INFORMATION 'Designated by NU 21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Re R. F. J.	ITAD. NP JCC) Blate A-L to service In C. G. K. ID. PROCEDURE G. CPT/HCPCS CPT/HCPCS 26. PATIENT'S ACCO 32. SERVICE FAGIL T	PI	FROM 2C. OUTS DE LAB? 22. FESUBMISSIÓN 23. FRIOFI AUTHORIZATION NUME F	SCHARGES IGNAL REF. NO. EF NPI NPI NPI NPI NPI NPI NPI NP

П							I
H						 	+
	72:250 						+
	HEALTH INSURANCE CLAIM FOR	RIVI				AR BIE	+
	APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (N						+
	PCA					PICA PICA	I
Н	1 MEDICARE MEDICAID TRICARE	CHAMP\ (Member I	L HEALT	JP THI PLAN BLK LUI X ((ID#)	G X (ID#)	R 1a. INSURED'S I.D. NUMBER (Fel Program in 1941 1)	+
	2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	,	3. PATIENT'S	BIRTH DATE	SEX	4. INSURED S NAME (Last Name, First Name, Middle Initial)	_
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	6. PATIENT R	X XX MX RELATIONSHIP TO INS	F X	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
Н	XXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	Self X S	Spouse X Child X	Other X	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
	CITY XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	STATE	8. RESERVED	D FOR NUCC USE		CITY STATE STATE	1
	ZIP CODE TELEPHONE (Include Area	Code)		XXXXXXXXX		(XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		XXXXXX	XXXXXXXX	XXXXX	(XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	1
	9. OTHER INSURED'S NAME (Last Name, First Name Middle		10. IS PATIEN	NT'S CONDITION RELA	TED TO:	11. INSURED'S POLICY GROUP OF FECA NUMBER XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
	a, OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYM	IENT? (Current or Previ	ous)	a INSUREDIS DATE OF BIFTH SEX	†
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	b. AUTO ACC	X YES X NO		XX XX XXX MX FX	+
	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	Dinorphia	X YES X NO	PLACE (State)	b. OTHER CLAIM ID (Clesignated by NWCC)	+
	c RESERVED FOR NUCC USE		c. OTHER AC	CCIDENT?		C. INSURANCE PLAN NAME OR PROGRAM NAME	I
	d, INSURANCE PLAN NAME OR PROGRAM NAME	^^^^	10d. CLAIM C	CODES (Designated by	NUCC)	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	XXXXXX	XXXXXXXX	XXXXX	X YES X NC If yes, complete items 9, 9a and 9d.	<u> </u>
	READ BACK OF FORM BEFORE C 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I a to process this claim. I also request payment of government be	OMPLE TIME athorize the nefits either	G & SIGNING TH	HIS FORM. nedical or other informat he party who accepts as	ion necessary	13. INSUFED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for	+
	below	nems eme	to mysen or to in	ne party who accepts as	signineni	services described below XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	$^{+}$
	SIGNED XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXX DAT	EXXXXXXX	XXXXX	SGNED XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
	14. DATE OF CURRENT ILLINESS, INJURY OF PREGNANCY (XX XX XXXX QUA XXX	QU	OTHER DATE	XXXX X	XXX	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM XX XX XXXX TO XX XX XXXX	+
	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	XXX		VVVVVVVV	VVVVV	18. HOSP TALIZATION DATES RELATED TO CURRENT SERVICES MM DD DD YY	Į
	19. ADDITIONAL CLAIM NFORMATIC N (Designated by NUCC	X X X 17	o. NPIXXXX XXXXXXXX	XXXXXXXXX	XXXXX	FROM X X X X X X X X X	+
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	XXXXXX	XXXXXXXX	XXXXX	X YES X NO XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	İ
	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate	A-L to sen	rice line below (2	24E) ICD Ind. X	VVVVV	22. FE\$UBMISSION ODE XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
	E XXXXXXX E XXXXXX	Ψ	XXXXXXX	X XX	XXXXX	23. PRIOR AUTHORIZATION NUMBER	\pm
	1. XXXXXXXX J. XXXXXXX 24. A. DATE(S) OF \$ERVICE B. C.	r. 2	XXXXXXX	X L. XX	XXXXX E.		\perp
	MM DD YY MM DD YY SERVICE EMG	(Expl	ain Unusual Circi	cumstances) MODIFIER	DIAGNOSIS POINTEF	F. G. H. I. J. Z. ANTENNA D. RENDERING D. SCHARGES UNITS PIP OUAL PROVIDER ID. # H.	+
	1 XX	VVV,				W	I
H	XX XX XX XX XX XX XX XXXX	XXX	^^ ^^	XX XX XX	XXXX	XXXXXXX XX XX XX NP XXXXXXXXXXX 5	+
	FXX XX XX XX XX XX XXXXX	XXX	XX XX	XX XX XX	XXXX	XXXXXXXX XX XX XX XP XXXXXXXXXX	1
	3 xx	XXX	XX XX	XX XX XX	XXXX	XXXXXXXX XXX XX NPI XXXXXXXXXX	+
	<u> </u>						+
	TXX XX XX XX XX XX XXXXX	XXX	XX XX	XX XX XX	XXXX	XXXXXXXX XXX XX NPI XXXXXXXXXXXX	+
H	5 xx	XXX	XX XX	XX XX XX	XXXX	XXXXXXXX XXX XXX NPI XXXXXXXXXXXXXXXXXXX	t
	6xx xx xx xx xx xx xx xxxxx	VVV.	VV			XXXXXXXX XXX XX NP XXXXXXXXXX	I
H		XXXX ATIENT'S	XX XX ACCOUNT NO.		SIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Risvet for NUCC Use	+
Ħ	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	XXXXXX	XX X YES X	NO		I
H				ION INFORMATION X		33. BILLING PROVIDER INFO & PH # (XXX) XXXXXXXXXXX	+
Ħ	apply to this bill and are made a part thereof.)	XXXX	XXXXXX	XXXXXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	#
\parallel	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	XXXXXXX	XXXXXXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	+
H	NUCC Instruction Manual available at: www.nucc	org	PLEA	XXXXXXXXX ASE PRINT OR 1	YPE	a XXXXXXXXXXX b XXXXXXXXXXXXXXXXXX	\pm
H							f
H							+
_							_