Co-insurance Deductible after Blue Cross

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | 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): 0012999888

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MILLER EVAN

3. PATIENT'S BIRTH DATE: 05 01 2007 SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MILLER EVAN

5. PATIENT'S ADDRESS (No., Street): 123 DEWITT STREET

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): 123 DEWITT STREET

CITY: CADILLAC STATE: MI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY: CADILLAC STATE: MI

ZIP CODE: 49601 TELEPHONE (Include Area Code): ( )

ZIP CODE: 49601 TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: VYP965485262

a. OTHER INSURED'S POLICY OR GROUP NUMBER: P123123

a. EMPLOYMENT? (Current or Previous): YES | X NO

a. INSURED'S DATE OF BIRTH: 05 01 2007 SEX: M | F X

b. OTHER INSURED'S DATE OF BIRTH: 02 20 1980 SEX: M X | F

b. AUTO ACCIDENT? YES | X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: UKNOWN

c. EMPLOYER'S NAME OR SCHOOL NAME: TJ MAXX INC

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS BLUE SHIELD OF MICHIGAN

d. INSURANCE PLAN NAME OR PROGRAM NAME: COFINITY PRINCIPAL INS

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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: 12/31/2008

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: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BAYLESS MICHAEL DO

17a.

17b. NPI: 1236916752

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 07 24 2008 TO MM DD YY

19. RESERVED FOR LOCAL USE: CARRIER ID: 30935005 CARRIER ID: 00029005

20. OUTSIDE LAB? YES | X NO $ CHARGES

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

1. 553.21
2.
3.
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	07 25 08		07 25 08			22		00832	AA	1	920 00	50		NPI	1669852658
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

CAS Codes/Other Insurance Information

	Payor	Line	Group Cd	Reason Cd	Amount/Date
1.	1	1	CO	45	92.00
2.	1	1	CO	DTPD	082508
3.	1	1	CO	PD	745.20
4.	1	1	PR	2	82.80
5.	2	1	CO	96	837.20
6.	2	1	CO	DTPD	103008
7.	2	1	CO	PD	0.00
8.	2	1	PR	1	82.80

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 38121212122 SSN | X EIN

26. PATIENT'S ACCOUNT NO.: 600509

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ 920 00

29. AMOUNT PAID: $ 745 20

30. BALANCE DUE: $ 82 80

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.)

GILLIS EDWARD MD

SIGNED 12/31/2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

LANSING GENERAL HOSPITAL
333 CAS STREET
LANSING MI 48909

a. 1866280254 b.

33. BILLING PROVIDER INFO & PH # (616) 364-5555

SPARK CONSULTANT
212 MICHIGAN AVE
HOLT MI 48820

a. 1990159662 b.