Commercial Insurance
Co-Insurance

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) 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): 0082223277
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JOHN, M	3. PATIENT'S BIRTH DATE MM DD YY: 02 20 2004 SEX M [X] F [ ]
	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, MARY, M
5. PATIENT'S ADDRESS (No., Street): 333 LAKE AVENUE	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
	7. INSURED'S ADDRESS (No., Street): 333 LAKE AVENUE
CITY: FAKE CITY STATE: MI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
	CITY: FAKE CITY STATE: MI
ZIP CODE: 48820 TELEPHONE (Include Area Code): (517) 668-3211	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
	ZIP CODE: 48820 TELEPHONE (Include Area Code): (517) 668-3211
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: 49078321053 6
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
	a. INSURED'S DATE OF BIRTH MM DD YY: 05 27 1971 SEX M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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: 12/25/2020	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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: COLES, DOCTOR	17a. 17b. NPI 1778260585
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 380.10 2. V04.81 3. 4.	22. MEDICAID 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 11 20 08	11	N	99213		1	79 00	1		NPI	1778260585
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	9.14
2.	1	1	CO	DTPD	121408
3.	1	1	CO	PD	49.86
4.	1	1	PR	2	20.00

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 366211403	26. PATIENT'S ACCOUNT NO.: 2018832-65	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 79 00
29. AMOUNT PAID: $ 49 86	30. BALANCE DUE: $ 20 00		
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.) COLES, DOCTOR SIGNED 12/25/2008 DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) MEDICAL CENTER 111 MAIN STREET A CITY, MI 49635 a. 1550822685 b.