1500

HEALTH INSURANCE CLAIM FORM

Medicare Deductible

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) [X] | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0055448403

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DEDUCTIBLE, MARY

3. PATIENT'S BIRTH DATE: 08 06 1981 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DEDUCTIBLE, MARY

5. PATIENT'S ADDRESS (No., Street): 111 MEDCIAID STREET

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

7. INSURED'S ADDRESS (No., Street): 111 MEDICAID STREET

CITY: CITY | STATE: MI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: CITY | STATE: MI

ZIP CODE: 48913 | TELEPHONE (Include Area Code): (269) 555-5252

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 48913 | TELEPHONE (Include Area Code): (269) 555-5252

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: 321654456A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 08 06 1981 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: MEDICARE

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

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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 03 07 2008

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

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: Carrier ID:44444444

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. 346.90
2. 780.4
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	03	07	08			23	Y	99284	UD	1,2	327 00	1		NPI	1148469244
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	217.94
2.	1	1	CO	DTPD	010209
3.	1	1	CO	PD	0.00
4.	1	1	PR	1	109.06

25. FEDERAL TAX I.D. NUMBER: 365299235 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: P4455750876

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

28. TOTAL CHARGE: $ 327 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 109 06

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.)

HOUSER MD, DOOGIE SIGNED 03/19/2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

HOSPITAL
1111 HEALTH SE
CITY, MI 49506

a. 1933909455 b.

33. BILLING PROVIDER INFO & PH # ( )

TAKE CARE
1 CLINIC STREET
CITY, MI 49506

a. 1096739685 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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