1500

Multiple Surgery

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

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): 12882505

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CHAMPS, ERIN

3. PATIENT'S BIRTH DATE MM DD YY: 04 19 1972 — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CHAMPS, ERIN

5. PATIENT'S ADDRESS (No., Street): 333 PATIENT RD

CITY: LANSING — STATE: MI

ZIP CODE: 48913 — TELEPHONE (Include Area Code): (517) 241-1111

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

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

7. INSURED'S ADDRESS (No., Street): 333 PATIENT RD

CITY: LANSING — STATE: MI

ZIP CODE: 48913 — TELEPHONE (Include Area Code): (517) 241-1111

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: XYP744125632 85235

a. INSURED'S DATE OF BIRTH MM DD YY: 04 19 1972 — SEX M [ ] F [X]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBS

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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 08/24/2008

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

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

17a. — 17b. NPI 9876543210

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 22 2008 TO 08 23 2008

19. RESERVED FOR LOCAL USE: OP NOTE WAS SUBMITTED THROUGH EZ-LINK

20. OUTSIDE LAB? YES [ ] NO [ ] — $ CHARGES

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

1. 618 . 5
2. 625 . 6
3. 618 . 6
4. 569 . 1

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 526456852

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	08	22	2008	08	22	2008	21	N	57284		1	2225 00	1		NPI	
2	08	22	2008	08	22	2008	21	N	57288		2	2175 00	1		NPI	
3	08	22	2008	08	22	2008	21	N	57265		3	2100 00	1		NPI	
4	08	22	2008	08	22	2008	21	N	45541		4	2100 00	1		NPI	
5	08	22	2008	08	22	2008	21	N	46750		4	1430 00	1		NPI	
6	08	22	2008	08	22	2008	21	N	58999		4	1650 00	1		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 382452544 — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 526985-85

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

28. TOTAL CHARGE: $ 11680 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 11680 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.)

BAYLESS MD, MICHAEL — 09/06/2008

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION

HOSPITAL
111 SURGERY
CITY, MI 48911

a. 1414141414 — b.

33. BILLING PROVIDER INFO & PH # (517) 335-9595

MICHAEL BAYLESS MD
320 S WALNUT
LANSING, MI 48913

a. 9876543210 — b.