1500

Replacement Claim

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0098595252

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, DARLENE

3. PATIENT'S BIRTH DATE MM DD YY: 06 19 1974 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, DARLENE

5. PATIENT'S ADDRESS (No., Street): 2 CHAMPS RD

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): 2 CHAMPS RD

CITY: PRETEND STATE: MI

8. PATIENT STATUS: Single ( ) Married ( ) Other ( ) Employed ( ) Full-Time Student ( ) Part-Time Student ( )

CITY: PRETEND STATE: MI

ZIP CODE: 41111 TELEPHONE (Include Area Code): ( )

ZIP CODE: 41111 TELEPHONE (Include Area Code): ( )

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:

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: 06 19 1974 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: MEDICAID

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

PHYSICIAN OR SUPPLIER INFORMATION

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

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE: IT WAS ORIGINALLY BILLED WITH INCORRECT DIAGNOSIS

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. 882.0 3. 959.4

2. E92.08 4.

22. MEDICAID RESUBMISSION CODE: 7 ORIGINAL REF. NO.: 9091123456

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	12	27	08	12	27	08	23	Y	12002		1,2	306 00	1		NPI	1234567890
2	12	27	08	12	27	08	23	Y	99283	UD 25	3	177 00	1		NPI	1234567890
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 361219898

26. PATIENT'S ACCOUNT NO.: D987456321523

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

28. TOTAL CHARGE: $ 483 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 483 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.)

JONES, CHESTER SIGNED 02/23/2009 DATE

32. SERVICE FACILITY LOCATION INFORMATION

HOSPITAL
100 MICHIGAN RD
LANSING, MI 48913

a. 1922532554 b.

33. BILLING PROVIDER INFO & PH # ( )

EMERGENCY
PO BOX 1111
LANSING, MI 48906

a. 1095235869 b. G2101916710