# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

AETNA CHOICE
15-2

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ABC103562239

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WILLIAMS WALTER

3. PATIENT'S BIRTH DATE MM DD YY: 09 04 1942 SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): WILLIAMS VAREEN

5. PATIENT'S ADDRESS (No., Street): 17 MILL ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: BROOKLYN STATE: OH

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 44144 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: BDC1001

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 401269939A

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: 07 14 1951 SEX: M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA CHOICE

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE NATIONWIDE

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☒ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

**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 SOF DATE 01 01 2016

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 SOF

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I10 B. R53 83 C. D.

E. F. G. H.

I. J. K. L.

22. 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 | 10 03 16 | | 10 03 16 | | | 11 | | 36415 | | AB | 17 00 | 1 | | NPI | 8877365552 |
| 2 | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | NPI | |

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 161234567 ☒

26. PATIENT'S ACCOUNT NO.: WILLIWA0

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

28. TOTAL CHARGE: $ 17 00

29. AMOUNT PAID: $ 15 00

30. Rsvd for NUCC Use

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.)

SIGNED SOF DATE

32. SERVICE FACILITY LOCATION INFORMATION

VALLEY ASSOCIATES PC
1400 WEST CENTER STREET
TOLEDO OH 43601 0123

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( 555 ) 967-0303

CHRISTOPHER CONNOLY MD
1400 WEST CENTER STREET
TOLEDO OH 43601 0123

a. 8877365552 NPI b.