HEALTH INSURANCE CLAIM FORM

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

CAREPLUS WORKERS COMP
15-6

CARRIER

PICA ☐☐☐ PICA ☐☐☐

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

PATIENT AND INSURED INFORMATION

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
1045891 22	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX
YANG SHIH CHI	12 03 1975 / M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
J&M MANUFACTURING	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
6 SPARROW RD	Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	
ZIP CODE / 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	
OH 3967	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY / 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	
CAREPLUS WORKERS COMPENSATION	
d. INSURANCE PLAN NAME OR PROGRAM NAME	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 _____ 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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
11 01 2016 QUAL.	QUAL.	FROM 11 01 2016 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. 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. S62 92XB B. 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 11 11 16	11 11 16	11		26600		A	315 00	1		NPI	88773655522
2 11 11 16	11 11 16	11		73130		A	91 00	1		NPI	88773655522
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
161234567 ☒	YANGSHI0	☐ YES ☐ NO	$ 406 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOF	VALLEY ASSOCIATES PC 1400 WEST CENTER STREET TOLEDO OH 43601 0123	(555) 321-0987 SARAH HAMISON MD (ORTHOPEDICS) 1400 WEST CENTER STREET TOLEDO OH 43601 0123
SIGNED DATE	a. NPI b.	a. 88773655522 b.