HEALTH INSURANCE CLAIM FORM

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

MEDICARE-MEDIGAP
15-10

CARRIER

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PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 138021649A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): AIKEN DONALD

3. PATIENT'S BIRTH DATE (MM DD YY): 04 30 1941 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 24 BEACON CREST DRIVE

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

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

CITY: SANDUSKY STATE: OH

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 44601 TELEPHONE (Include Area Code): ( )

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 138021649B

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

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX: M [ ] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE NATIONWIDE

d. INSURANCE PLAN NAME OR PROGRAM NAME: AARP MEDIGAP

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 10 10 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

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

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 [X] NO $ CHARGES

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

A. D51 0 B. R17 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	10	16	10	10	16	11		99203		AB	69 00	1		NPI 88773655522
2	10	10	16	10	10	16	11		36415		AB	17 00	1		NPI 88773655522
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: 161234566 [ ] [X]

26. PATIENT'S ACCOUNT NO.: AIKENDO0

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

28. TOTAL CHARGE: $ 86 00

29. AMOUNT PAID: $

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 CONNOLLY MD
1400 WEST CENTER STREET
TOLEDO OH 43601 0123

a. 88773655522 b.