HEALTH INSURANCE CLAIM FORM

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

MEDICARE-MEDIGAP
15-14

CARRIER

PICA ☐☐☐ PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (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): 14324102A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ESTEPHAN WILMA

3. PATIENT'S BIRTH DATE MM DD YY: 03 14 1946 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 109 RIVER RD

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

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

CITY: CELVELAND | STATE: OH

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 44101 | TELEPHONE (Include Area Code): ( )

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

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

10. IS PATIENT'S CONDITION RELATED TO:

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: MEDIGAP 099655820

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? [ ] 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

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

PHYSICIAN OR SUPPLIER 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. 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 05 16	10 05 16	11		99211			A	14 00	1		NPI	8877365552
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 161234567

26. PATIENT'S ACCOUNT NO.: ESTEPWI0

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

28. TOTAL CHARGE $ 14 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. 8877365552 NPI b.