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HEALTH INSURANCE CLAIM FORM	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	
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1. MEDICARE MEDICAID TRICARE CHAMP\	— HEALTH PLAN — BLK LUNG —
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other
CITY STATE	8. RESERVED FOR NUCC USE CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include Area Code)
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) a. INSURED'S DATE OF BIRTH SEX
	YES NO MM DD YYY M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?
3.1120211125 7 0.111600 002	□ YES □ NO MEDICARE ADVANTAGE
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 COMPLETIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either below.	release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for
SIGNED	DATE SIGNED
MM + DD + VV	OTHER DATE OTHER DATE MM DD YY
QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.	18 HOSPITALIZATION DATES BELATED TO CURRENT SERVICES
17	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES
CT01234567 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service	VES NO VIIIne helow (24F)
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20. PATIENTS	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use Type No \$ \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	ACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Dr. A
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SIGNED DATE	D b. a. ND b.
NUICC Instruction Manual qualitable at your pure and	DI EASE DRINT OR TYPE APPROVED OMB 0038 1107 FORM 1500 (02.12



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TH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 1. MEDICARE 1a. INSURED'S I.D. NUMBER CHAMPVA OTHER (For Program in Item 1) **MEDICAID** TRICARE GROUP HEALTH PLAN *(ID#)* FECA BLK LUNG (ID#) (ID#) (Medicare#) (Medicaid#) (ID#/DoD#) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SEX 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) Spouse Child Other 8. RESERVED FOR NUCC USE CITY STATE STATE CITY INFORMATION ZIP CODE ZIP CODE TELEPHONE (Include Area 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 INSURED a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) SEX м FΓ YES b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) **IENT AND**]NO [YES c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES MEDICARE ADVANTAGE d. INSURANCE PLAN NAME OR PROGRAM NAME 10d, CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Пио YES If yes, complete items 9, 9a, and 9d-13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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 payment of medical benefits to the undersigned physician or supplier for services described below. 15. OTHER DATE URRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD VV QUAL. QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17b. NP FROM 20. OUTSIDE LAB? 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) \$ CHARGES CT01234567 YES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ORIGINAL REF. NO. A. LZ00.6 B. I c. L D. 23. PRIOR AUTHORIZATION NUMBER E. L F. I G. L H. L D. PROCEDURES, SERVICES, OR SUPPLIES DATE(S) OF SERVICE В. E. DIAGNOSIS J. RENDERING SUPPLIER INFORMATION PLACE OF ID. QUAL (Explain Unusual Circumsta DD CPT/HCPCS MODIFIER \$ CHARGES PROVIDER ID. 12 24 16 12 24 16 71260 **Q1** 1 NPI 12 24 16 12 24 78300 01 NPI 3 NPI SICIAN OR NPI NPI 6 NPI 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use YES NO \$ 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 33. BILLING PROVIDER INFO & PH # 32. SERVICE FACILITY LOCATION INFORMATION (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Dr. B

1	2		3a PAT. CNTL #		4 TYPE OF BILL
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HEALTH INSURANCE CLAIM FORM

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FINAL VISIT

HEALTH INSURANCE CLAIM FORM

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

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A PATIENT RELATIONS TO RESURED		(M	edicare	e#)	(Medic	aid#)	(ID#	/DoD#)		(Mem	ber ID#)	HEA (ID#)	LIHPLA		(ID#)	_UNG [(ID#)										
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TOTAL STATE CODE TELEPHONE (Include Area Cude) TELEPHON	5. F	PATI	ENT'S	ADDRE	SS (No.	, Street)					6. F	PATIENT	RELATI	ONSHIE	TOI	INSURE	D	7. INSURED'S ADDRESS (No., Street)									
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