DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

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

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PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 555-55-5555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, D.

3. PATIENT'S BIRTH DATE: 06 11 — SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Davenport

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

7. INSURED'S ADDRESS (No., Street): 123 Davenport

CITY: Grand Rapids — STATE: MT

8. RESERVED FOR NUCC USE

CITY: GRAND RAPIDS — STATE: MI

ZIP CODE — TELEPHONE (Include Area Code): ( )555-1212

ZIP CODE: 49512 — TELEPHONE (Include Area Code): (111) 555-1212

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: XYO666555222

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 02 53 — SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): NONE

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BC/BS

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] 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 2-12-14

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 [signature]

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 2 1 13 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: DR. JOHN DOE

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.

A. 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	2 1 13 2 12 13	0			51		105573	11		NPI	LI-21389
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6							105573			NPI	

25. FEDERAL TAX I.D. NUMBER: LI-21389 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DJ02133

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

28. TOTAL CHARGE: $ 105573

29. AMOUNT PAID: $ 105

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 [signature] DATE 2-14-13

32. SERVICE FACILITY LOCATION INFORMATION: DOE MEDICAL CHIROPRACTIC MEDICAL OFFICE 555 North St GRAND RAPIDS, MT

a. b.

33. BILLING PROVIDER INFO & PH # ( ) BILLING SERVICES 123 NORTH ST. GRAND RAPIDS, MI

a. b.

NUCC Instruction Manual available at: www.nucc.org

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OMB APPROVAL PENDING