

DATE RECEIVED: 06/15/2009  
DATE PAID: 07/12/2009

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 023456701																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mouse, Michael A.										3. PATIENT'S BIRTH DATE MM DD YY 01 12 45					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Mouse, Michael A.																			
5. PATIENT'S ADDRESS (No., Street) 127 Minerva Beach Ave										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 127 Minerva Beach Ave																								
CITY Lake Worth					STATE FL					8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>					CITY Lake Worth					STATE FL																			
ZIP CODE 33463					TELEPHONE (Include Area Code) ( )					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 33463					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																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY 01 12 45										SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
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. Signature on File 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. Signature on File SIGNED _____																													
14. DATE OF CURRENT: MM DD YY 05 30 2009					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 996.41										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 06 08 09 06 08 09 21		2		22852 80 54 66 99				1		400 00 01																													
2																																							
3																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER 59-1234567					SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 555-0245M					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 400 00					29. AMOUNT PAID \$					30. BALANCE DUE \$ 400 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 A Memorial Hospital 3501 Johnson Street Hollywood FL 33021										33. BILLING PROVIDER INFO & PH # (954) 989-0000 Dr. Lennie Sharper 4310 Sheridan Street Lake Worth FL 33463																			
SIGNED _____ DATE _____										a. _____					b. _____					a. _____					b. ME652202														

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1500

DATE RECEIVED: 10/12/2009  
DATE PAID: 10/14/2009

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 023456702																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) White, Yolanda										3. PATIENT'S BIRTH DATE MM DD YY 05 18 1953					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) White, Yolanda																			
5. PATIENT'S ADDRESS (No., Street) 52 Castle Rd										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY Tallahassee					STATE FL					8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE														
ZIP CODE 32308					TELEPHONE (Include Area Code) ( )					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										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																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY 05 18 53										SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
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. Signature on File										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on File																													
SIGNED _____ DATE _____										SIGNED _____																													
14. DATE OF CURRENT: MM DD YY 05 02 2009										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.					17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 842.02 2. E821.8										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 Part I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 10 01 09 10 01 09 11 99215 1 170 65 1										NPI										2 10 01 09 10 01 09 11 10021 2 270 50 1										NPI									
3										NPI										4										NPI									
5										NPI										6										NPI									
25. FEDERAL TAX I.D. NUMBER 59-3020333										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 666-55545					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 441 15					29. AMOUNT PAID \$					30. BALANCE DUE \$ 0 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 Physician's Care Ctr 1745 W. Pensacola St. Tallahassee, FL 32304										33. BILLING PROVIDER INFO & PH # Dr. Frank Spock P.O. Box 12345 Tallahassee, FL 32308																			
SIGNED _____ DATE _____										a.					b.					a.					b. ME652199														

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

DATE RECEIVED: 10/15/09

DATE PAID: 10/28/09

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 023456703																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Alexander, Katrina										3. PATIENT'S BIRTH DATE MM DD YY 07 04 57 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																			
5. PATIENT'S ADDRESS (No., Street) 301 First Street										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																			
CITY Hialeah STATE FL					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 301 First Street					CITY Hialeah STATE FL														
ZIP CODE 33012 TELEPHONE (Include Area Code) ( )					Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 33012 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									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY 07 04 57 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
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. Signature on File 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. Signature on File SIGNED _____																			
14. DATE OF CURRENT: MM DD YY 05 25 09					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										17b. NPI _____					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.2										3. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.														
2. _____										4. _____					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 03 09 10 03 09		11 01		97110				1		128 00 2						NPI											
2		10 03 09 10 03 09		11 01		97530				1		64 00 1						NPI											
3																		NPI											
4																		NPI											
5																		NPI											
6																		NPI											
25. FEDERAL TAX I.D. NUMBER 59-1281292 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 000254ALE					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 192 00					29. AMOUNT PAID \$					30. BALANCE DUE \$ 192 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 Physical Therapy Studio 1075 Mason Ave Miami Lake, FL 33014										33. BILLING PROVIDER INFO & PH # ( ) Orthopaedic Clinic P.O. Box 9368 Miami, FL 33116									
SIGNED _____ DATE _____										a. _____					b. PT54321														

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

DATE RECEIVED: 11/19/09  
DATE PAID: 11/30/09

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																						
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 023456704																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Albright, Michael					3. PATIENT'S BIRTH DATE MM DD YY 01 12 45					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Albright, Michael																																																	
5. PATIENT'S ADDRESS (No., Street) 4374 Silver Drive					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 4374 Silver Drive																																																						
CITY Daytona Beach			STATE FL		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>					CITY Daytona Beach			STATE FL																																																			
ZIP CODE 32114			TELEPHONE (Include Area Code) ( )		Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 32114			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																																																						
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY 01 12 45					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME																																																						
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																																																						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					If yes, return to and complete item 9 a-d.																																																	
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.  Signature on File 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.  Signature on File SIGNED _____																																																						
14. DATE OF CURRENT: MM DD YY 11 01 09					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																	
19. RESERVED FOR LOCAL USE					17b. NPI _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 812.41										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 01 09 11 01 09 11					COMP					1					100 00 10					NPI																																							
2					11 01 09 11 01 09 11					66336-0145-30					1					100 00 10					NPI																																							
3																				NPI																																												
4																				NPI																																												
5																				NPI																																												
6																				NPI																																												
25. FEDERAL TAX I.D. NUMBER 76-0726333					SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 4445558-A					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 200 00					29. AMOUNT PAID \$					30. BALANCE DUE \$ 200 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 Physician's Care Ctr 1745 W. Pensacola St. Tallahassee, FL 32304										33. BILLING PROVIDER INFO & PH # ( ) Dr. Frank Spock 1415 Homestead Rd. North Lehigh Acres, FL 33936																																												
SIGNED _____					DATE _____					a. _____					b. ME652199																																																	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

DATE RECEIVED: 09/28/2009

DATE PAID: 09/30/2009

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 023456709																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Tell, William					3. PATIENT'S BIRTH DATE MM DD YY 05 16 73 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Tell, William																			
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 05 16 73 M <input type="checkbox"/> F <input checked="" type="checkbox"/> SEX b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
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. Signature on File 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. Signature on File SIGNED _____																			
14. DATE OF CURRENT: MM DD YY 09 20 09					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER														
19. RESERVED FOR LOCAL USE										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 478.75 2. _____ 3. _____ 4. _____																			
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 09 20 09 09 20 09 11						73030 RT				1		38 00 1																	
2 09 20 09 09 20 09 11						99215				1		133 00 1																	
3 09 20 09 09 20 09 11						97035				1		70 50 1																	
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER 59-1234567					26. PATIENT'S ACCOUNT NO. 554876T-05					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 241 50					29. AMOUNT PAID \$					30. BALANCE DUE \$ 241 50				
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 _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION A Memorial Hospital 3501 Johnson Street Hollywood FL 33021 a. _____ b. _____										33. BILLING PROVIDER INFO & PH # ( ) Dr. Lennie Sharper 4310 Sheridan Street Lake Worth FL 33463 a. _____ b. ME652202									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION