HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

1. MEDICARE (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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John, A

3. PATIENT'S BIRTH DATE MM DD YY: 05 17 64 — SEX: M ✔ F

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

5. PATIENT'S ADDRESS (No., Street): 555 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self ✔ Spouse Child Other

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

CITY: Plano — STATE: TX

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE: 94908 — TELEPHONE (Include Area Code): (949) 785-6655

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) YES NO ✔

a. INSURED'S DATE OF BIRTH MM DD YY: 05 17 64 — SEX: M ✔ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO ✔ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO ✔

c. INSURANCE PLAN NAME OR PROGRAM NAME: UFCW Employers Trust Fund

d. INSURANCE PLAN NAME OR PROGRAM NAME: UFCW Employers Trust Fund

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 Signature on File — DATE 03-25-14

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 on File

PATIENT AND INSURED 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 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. 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: 75445M3455J3

Line	24. A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	0	17	14	01	17	14	11		90834		1	94 15	1		NPI	175066074
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 115294595 — SSN EIN ✔

26. PATIENT'S ACCOUNT NO.: 752545 58785

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✔ NO

28. TOTAL CHARGE: $ 94 15

29. AMOUNT PAID: $ 00

30. Rsvd for NUCC Use: 94 15

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: Comprehensive Psych Center, 4540 Prey Way, Plano TX 94985

a. 102545896 — b.

33. BILLING PROVIDER INFO & PH #: (949) 8545478

a. 1025458963 — b.

SAMPLE