AEKNA

4345 DONKEY ROAD
LONGVIEW, FL 44433

# HEALTH INSURANCE CLAIM FORM

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

X 555

PICA

BELFORD, PHIL 02 09 1972 X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): BELFORD, PHIL.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): 6666 STRING STREET

3. PATIENT'S BIRTH DATE: X SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): 6666 STRING STREET

5. PATIENT'S ADDRESS (No., Street): LONGVIEW FL

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: 44433 STATE: 333 4442222

8. RESERVED FOR NUCC USE

CITY: 44433 STATE: 333 4442222

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

ZIP CODE: 444 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: 02 09 1972 X

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC): USING PENS INC

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? X YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: BAD PLAN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): 34

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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.

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.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 11 07 2023 QUAL 431

15. OTHER DATE: QUAL 454 11 07 2023

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 11 07 2023 TO 11 07 2023

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 11 07 2023 TO 11 07 2023

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? X YES NO $ CHARGES 99999

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 5851 B. 4010 C. 29620 D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE 21 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 | $ CHARGES | F. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | EWRWEWEWR | | | NPI | |
| 2 11 07 23 | 11 07 23 | 01 | | 99215 | | AB | 0 00 | 1 | | 03 NPI | |
| 3 11 07 23 | 11 07 23 | 01 | | 99202 | | C | 200 00 | 1 | | 03 NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

X SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

1-15 X

GREAT CLINIC
665 ROADSBY ROAD
LONGVIEW FL 333222

33. BILLING PROVIDER INFO & PH # ( )

200 00 0 00 -

a. GREAT CLINIC
665 ROADSBY ROAD
LONGVIEW FL 333222

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SIGNATURE ON FILE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION