HEALTH INSURANCE CLAIM FORM

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

W600000
Carrier ZYZ
2000 Hydra Road
New York, NY 10001

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 987-65-4321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wolverine, Hugo

3. PATIENT'S BIRTH DATE: MM 10 DD 17 YY 1960 SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): XFactor Tactical Support

5. PATIENT'S ADDRESS (No., Street): 2619 Avenue North

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): 94 Jamaica Drive

CITY: Brooklyn — STATE: NY

8. RESERVED FOR NUCC USE

CITY: Jamaica — STATE: NY

ZIP CODE: 11235 — TELEPHONE (Include Area Code): (555) 5555555

ZIP CODE: 11422 — TELEPHONE (Include Area Code): (111) 1111111

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: G3000000

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: Wolverine^^^Hugo

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

b. OTHER CLAIM ID (Designated by NUCC): Y4 9900V13972

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? ( ) YES (X) NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Carrier ZYZ

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: Signature on File 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): MM 01 DD 02 YY 2020 QUAL. 431

15. OTHER DATE: QUAL. 454 MM 01 DD 03 YY 2020

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM 01 03 2020 TO 01 20 2020

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DQ Charles Xavier, MD

17a. 0B 272222

17b. NPI 1666699999

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): REFX5PA944444-8^^^G2PHYAS^^^PWK09EAC00985621^^^NTEADD20200302

20. OUTSIDE LAB? ( ) YES ( ) NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5020 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	01	20	20	01	20	20	11		99213	1D	A	84 29	1		0B	944444
															NPI	9877777777
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 211111110 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: WH002345

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

28. TOTAL CHARGE: $ 84 29

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.)
Jean, Gray PA
SIGNED 01/20/2020 DATE

32. SERVICE FACILITY LOCATION INFORMATION
OSCORP Orthopedic Associates
490 Western Ave
Brooklyn NY 11235
a. 1666699999 b.

33. BILLING PROVIDER INFO & PH # (222) 2222222
XMen Billing Services
200 Shore Drive
Great Neck NY 12345
a. 1666699997 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION