EXAMPLE - SELF EMPLOYED PT

HEALTH INSURANCE CLAIM FORM

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

W700000
Comp4U Insurance
1234 Shield Street
Newburgh, NY 12550

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Arden, Dale

3. PATIENT'S BIRTH DATE MM 09 DD 08 YY 1986 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Sky Caterers, LLC

5. PATIENT'S ADDRESS (No., Street): 13 Troy Gardens

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

7. INSURED'S ADDRESS (No., Street): 94 Blue Wren Avenue

CITY: Corona STATE: NY

8. RESERVED FOR NUCC USE

CITY: Jackson Heights STATE: NY

ZIP CODE: 11368 TELEPHONE (Include Area Code): (111) 1111111

ZIP CODE: 11372 TELEPHONE (Include Area Code): (222) 2222222

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: G7654321

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: Arden^^^Dale

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

b. OTHER CLAIM ID (Designated by NUCC): Y4 317MU202451W

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: Comp4U Insurance

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 12 DD 10 YY 2019 QUAL. 431

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: DN Ming, Mercedes MD

17a. 0B 975555

17b. NPI 2888888888

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
REFX5PT005555-1^^^G2PT^^^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. M5416 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	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	01	20	01	01	20	11		97110					A	37 91	1		0B NPI	654321 2777777777
2	01	01	20	01	01	20	11		97124					A	25 02	1		0B NPI	654321 2777777777
3	01	01	20	01	01	20	11		97010					A	5 25	1		0B NPI	654321 2777777777
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER 260777777 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. 465198

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

28. TOTAL CHARGE $ 68 18

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.)
Flash Gordon, PT
SIGNED 01/01/2020 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Wellness PT Services
1 Saratoga RD
Astoria, NY 11102
a. 9777777777 b.

33. BILLING PROVIDER INFO & PH # (333) 3333333
Wellness PT Services
PO Box 12345
Woodside NY 11377
a. 9777777777 b.