EXAMPLE - RADIOLOGIST

HEALTH INSURANCE CLAIM FORM

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

W910000
State and Casualty Insurance
17 Avengers Street
White Plains, NY 10604

CARRIER

PICA

PICA

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): 123-45-6788

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Walker, Diana

3. PATIENT'S BIRTH DATE MM 07 DD 12 YY 1982 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 21 Acme Valley Road

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒

7. INSURED'S ADDRESS (No., Street): 17 Calvary Drive

CITY: Frankfort STATE: NY

8. RESERVED FOR NUCC USE

CITY: Utica STATE: NY

ZIP CODE: 13340 TELEPHONE (Include Area Code): (555) 5555555

ZIP CODE: 13502 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: G2111119

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

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

b. RESERVED FOR NUCC USE: Walker^^^Diana

b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): Y4 Y0078792156

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: State and Casualty Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

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

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 05 DD 27 YY 2018 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 Leon Mandrake

17a. 0B 110300

17b. NPI 5999777777

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): REFX5003333-4^^^G2RAD^^^PWK06EAC00985621^^^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. M79672 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	15	20	01	15	20	11		73630	LT				A	86 12	1		OB NPI	003333 6000888888
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER 160001111 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO. 0078

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

28. TOTAL CHARGE $ 86 12

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.)
Anthony Lothar, MD
SIGNED DATE 01/16/2020

32. SERVICE FACILITY LOCATION INFORMATION
Bangalla Imaging Associates
65 Wanderlust Circle
Syracuse NY 13208
a. 4888999999 b.

33. BILLING PROVIDER INFO & PH # (333) 3333333
Bangalla Imaging Associates
65 Wanderlust Circle
Syracuse NY 13208
a. 4888999999 b.