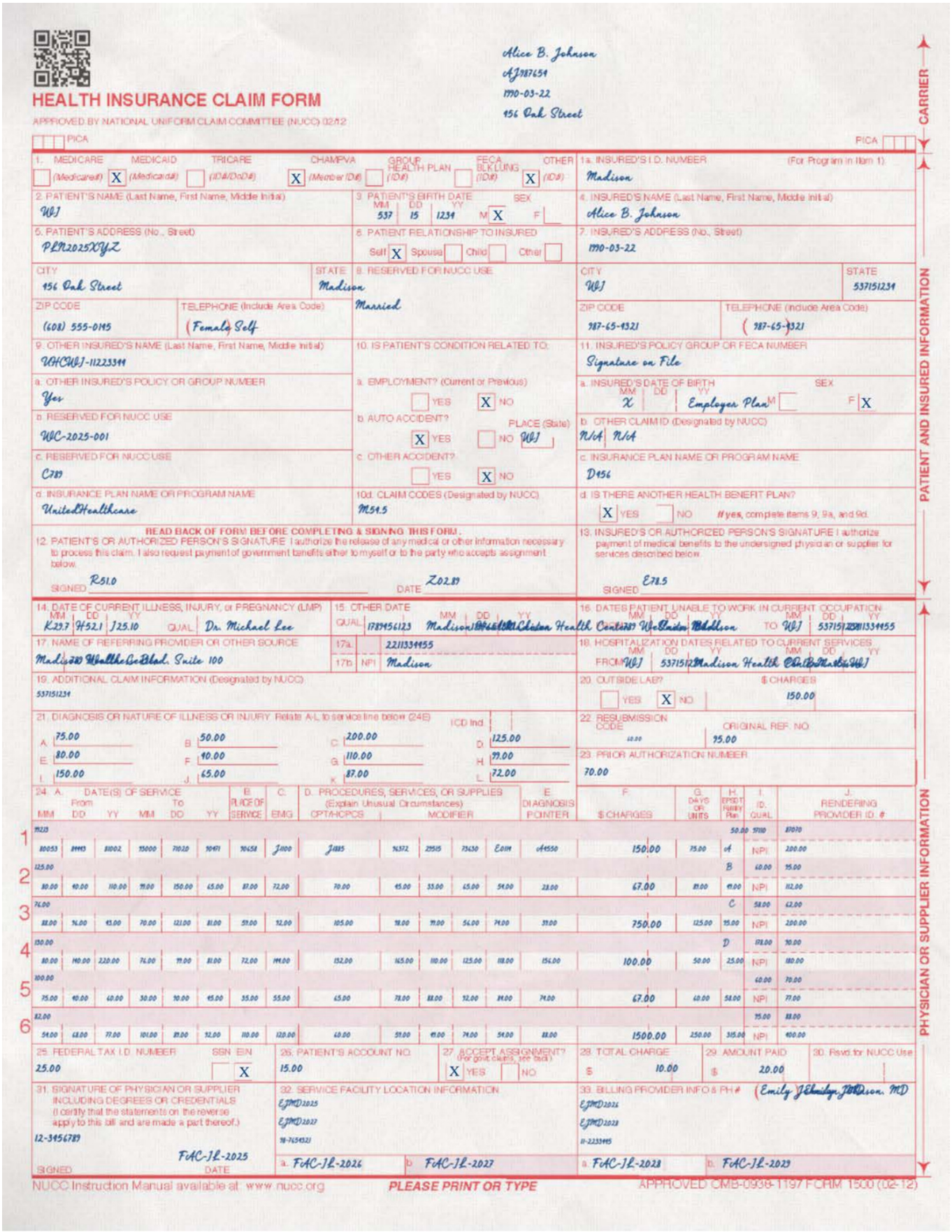

HEALTH INSURANCE CLAIM FORM

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

Alice B. Johnson
AJ387654
1990-03-22
456 Oak Street

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#) X	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#) X	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Madison			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
WBJ				537 15 1234			Alice B. Johnson				
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)				
PLN 2025 XYZ				Self X Spouse Child Other			1990-03-22				
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE		
456 Oak Street		Madison					WBJ		537151234		
ZIP CODE	TELEPHONE (Include Area Code)		Married				ZIP CODE	TELEPHONE (Include Area Code)			
(608) 555-0145	(Female) Self						987-65-4321	(987-65-4321)			
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				
UHC WBJ-11223344							Signature on File				
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX			
Yes			YES X NO				X Employer Plan	M F X			
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)				
WBC-2025-001			X YES NO WBJ				N/A N/A				
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME				
C789			YES X NO				D456				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
UnitedHealthcare			M54.5				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.

SIGNED R51.0 DATE Z02.89

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 E78.5

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
K29.7 H52.1 J25.10 QUAL Dr. Michael Lee	1789456123 Madison Health Center Wellness Addison		TO WBJ 537151234 11334455
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 2211334455		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
Madison Wellness Blvd. Suite 100	17b. NPI Madison		FROM WBJ 537151234 Madison Health Center Wellness WBJ
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? $ CHARGES
537151234			YES X NO 150.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind			22. RESUBMISSION CODE ORIGINAL REF. NO.
A. 75.00 B. 50.00 C. 200.00 D. 125.00			00 95.00
E. 80.00 F. 90.00 G. 110.00 H. 99.00			23. PRIOR AUTHORIZATION NUMBER
I. 150.00 J. 65.00 K. 87.00 L. 72.00			70.00

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 75.00										50.00	99110 87070
80053 01/15 01/02	15000	71020	10471	10458	J000	J1885	76372	25515	73630	E0114	A4550	150.00	75.00	01	NPI 200.00
2 125.00														B	60.00 150.00
80.00 40.00	110.00	99.00	150.00	65.00	87.00	72.00	70.00	45.00	33.00	65.00	54.00	23.00	67.00	99.00	99.00 NPI 112.00
3 74.00														C	58.00 62.00
88.00 56.00	45.00	70.00	121.00	81.00	59.00	52.00	105.00	98.00	99.00	56.00	74.00	39.00	750.00	125.00	55.00 NPI 200.00
4 150.00														D	178.00 90.00
80.00 110.00	220.00	76.00	99.00	81.00	72.00	144.00	152.00	145.00	110.00	125.00	118.00	154.00	100.00	50.00	25.00 NPI 180.00
5 100.00															60.00 70.00
75.00 40.00	60.00	30.00	90.00	45.00	35.00	55.00	65.00	78.00	88.00	52.00	39.00	74.00	67.00	60.00	58.00 NPI 77.00
6 82.00															95.00 88.00
54.00 68.00	77.00	101.00	89.00	52.00	110.00	120.00	60.00	59.00	49.00	74.00	54.00	88.00	1500.00	250.00	385.00 NPI 400.00

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd. for NUCC Use
25.00	X	15.00	X YES NO	$ 10.00	$ 20.00	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
12-3456789	EJMD2025	(Emily J Ehmidyn MD)son. MD
SIGNED FAC-JL-2025 DATE	EJMD2027	EJMD2024
	98-7654321	EJMD2028
	a. FAC-JL-2026 b. FAC-JL-2027	11-2233445
		a. FAC-JL-2028 b. FAC-JL-2029

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION