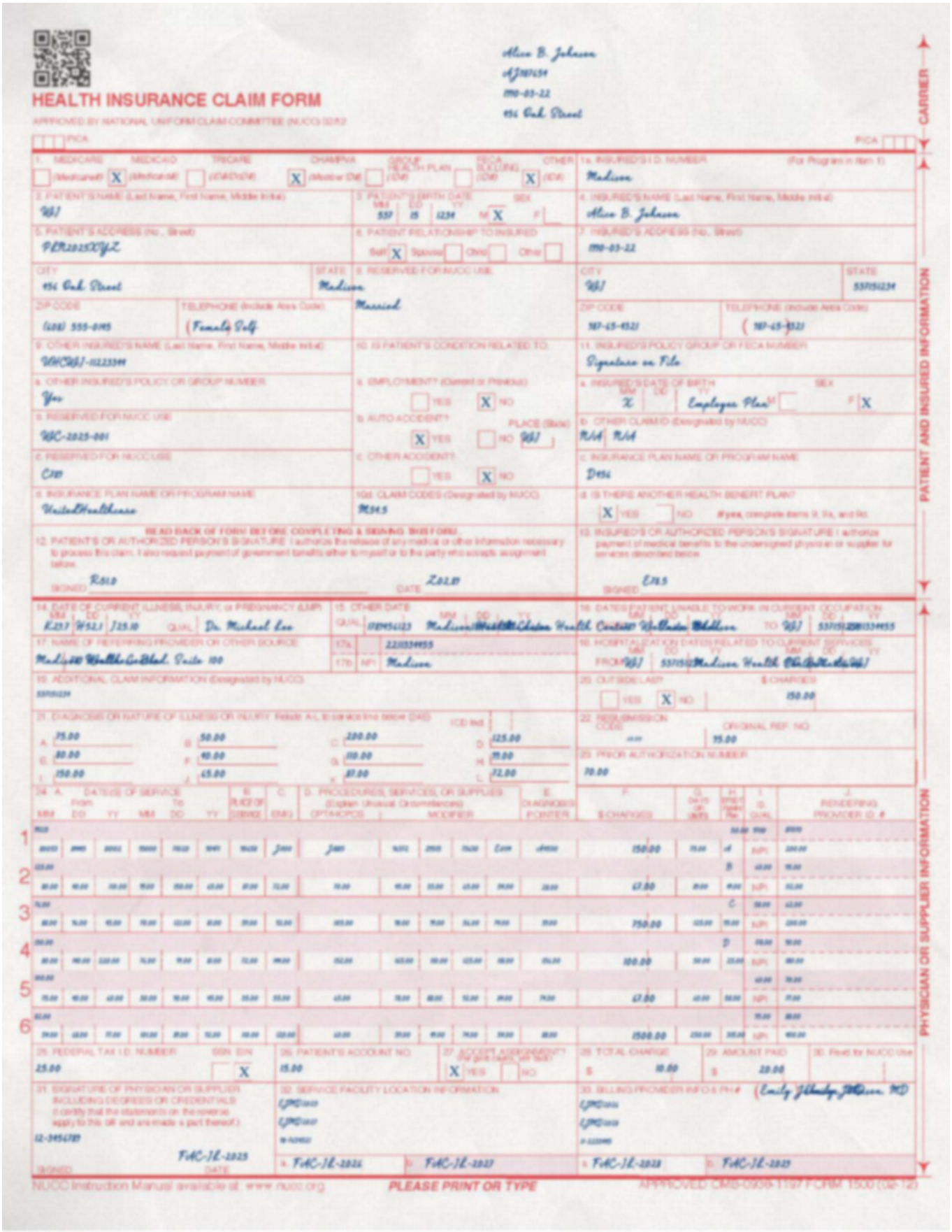

HEALTH INSURANCE CLAIM FORM

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

PICA

Alice B. Johnson
4J387154
1990-03-22
456 Oak Street

1. MEDICARE (Medicare#) X | MEDICAID (Medicaid#) | 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): Medicare

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

3. PATIENT'S BIRTH DATE: MM 05 DD 15 YY 1234 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Alice B. Johnson

5. PATIENT'S ADDRESS (No., Street): PER2025XYZ

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

7. INSURED'S ADDRESS (No., Street): 1990-03-22

CITY: 456 Oak Street | STATE: Madison

8. RESERVED FOR NUCC USE: Married

CITY: Self | STATE: 537151234

ZIP CODE: (608) 555-0145 | TELEPHONE (Include Area Code): (Female Self

ZIP CODE: 107-45-4521 | TELEPHONE (Include Area Code): (107-45-4521

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): WHCSelf-0123344

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Signature on File

a. OTHER INSURED'S POLICY OR GROUP NUMBER: Yes

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

a. INSURED'S DATE OF BIRTH: MM 2 DD | YY Employee Plan | SEX: M | F X

b. RESERVED FOR NUCC USE: WHC-2025-001

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

b. OTHER CLAIM ID (Designated by NUCC): N/A N/A

c. RESERVED FOR NUCC USE: CHP

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Desk

d. INSURANCE PLAN NAME OR PROGRAM NAME: UnitedHealthcare

10d. CLAIM CODES (Designated by NUCC): M54.5

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.

SIGNED: R.S.J. | DATE: 2.02.25

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: E.N.S.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 2 DD 5 YY 2025 | QUAL: Dr. Michael Lee

15. OTHER DATE: MM DD YY | QUAL: 1234567123 | Madison Health Clinic

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY | TO: Self | 537151234 MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Madison Health Center Blvd. Suite 100

17a. 2201334455 | 17b. NPI: Madison

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM Self | 537151 Madison Health Clinic

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 537151234

20. OUTSIDE LAB? YES | X NO | $ CHARGES: 150.00

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

A. 75.00 | B. 50.00 | C. 200.00 | D. 125.00
E. 80.00 | F. 90.00 | G. 110.00 | H. 95.00
I. 150.00 | J. 45.00 | K. 87.00 | L. 72.00

22. RESUBMISSION CODE: 7 | ORIGINAL REF. NO.: 55.00

23. PRIOR AUTHORIZATION NUMBER: 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					J301		150.00	75.00	A	NPI	200.00
2							47.50	85.00	B	NPI	12.00
3							750.00	125.00	C	NPI	200.00
4							100.00	50.00	D	NPI	90.00
5							47.50	45.00		NPI	77.00
6							1500.00	250.00		NPI	400.00

25. FEDERAL TAX I.D. NUMBER: 25.00 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 15.00

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

28. TOTAL CHARGE: $ 10.00

29. AMOUNT PAID: $ 20.00

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.): 12-3454789 | SIGNED: FAC-JL-2025 | DATE:

32. SERVICE FACILITY LOCATION INFORMATION: NPI 1111 | NPI 2222 | 98-7654321 | a. FAC-JL-2024 | b. FAC-JL-2027

33. BILLING PROVIDER INFO & PH #: (Emily Johnson, Clinic MD) | NPI 1111 | NPI 2222 | 0-1234567 | a. FAC-JL-2024 | b. FAC-JL-2027

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (08-12)