1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY THE UNIFORM CLAIM COMMITTEE 08/05

Name Here
Address
City, State
Zip

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (MemberID#) / GROUP HEALTH (SSN or ID) / FECA BLKLung (SSN) / OTHER (ID) [x]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): QCBxxxxxxxxxx

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

3. PATIENTS BIRTH DATE: MM 12 DD 10 YY 50 — SEX: M [x] F [ ]

4. INSURED'S NAME (Last Name, First name, Middle Initial): Jones, Harry

5. PATIENT'S ADDRESS (No., Street): 286 Lakeview Road

CITY: Happy Valley — STATE: PA

ZIP CODE: 19xxx — TELEPHONE (Include Area Code): (610) 552-xxxx

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

8. PATIENT STATUS: Single [x] Married [ ] Other [ ]; Employed [x] Full-Time Student [ ] Part Time Student [ ]

7. INSURED'S ADDRESS (No., Street): 286 Lakeview Road

CITY: Happy Valley — STATE: PA

ZIP CODE: 19xxx — TELEPHONE (Include Area Code): (610) 552-xxxx

9. OTHER INSURED'S NAME (Last Name, First Name, Middle In.)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [x]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Personal Choice

10. IS PATIENT CONDITION RELATED TO;

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [x]

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

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

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: MM 12 DD 10 YY 50 — SEX M [x] F [ ]

b. EMPLOYERS NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: Personal Choice

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [x] *If yes, return to and complete item 9 a-d.*

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM 08 DD 19 YY 10 — ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATED PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. 1B — 17b. NPI

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

19. RESERVED FOR LOCAL USE: 133V00000X

20. OUTSIDE LAB? YES [ ] NO [ ] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS (Relate Items 1,2,3 or 4 to item 24E by LINE)

1. V85 . 30
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	24. A. FROM MM	DD	YY	TO MM	DD	YY	B. Place of Service	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS or UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID#
1	08	19	10	08	19	10	11		97802			160 00	4		NPI	285xxxxxxx / 178xxxxxxx
2	09	08	10	09	08	10	11		97803			160 00	4		NPI	285xxxxxxx / 178xxxxxxx
3	10	07	10	10	07	10	11		97803			160 00	4		NPI	2856562000 / 178xxxxxxx
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 25-xxxxxx — SSN [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: xxxx

27. ACCEPT ASSIGNMENT? YES [ ] NO [ ]

28. TOTAL CHARGE: $ 480 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 480 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.)

SIGNED Catherine C. Happy DATE 3/14/09

32. SERVICE FACILITY LOCATION INFORMATION — a. — b.

33. BILLING PROVIDER INFO & PH # (484) 682-xxxx

Happy Valley Nutrition
12 Happy Lane
Happy Valley , PA 19xxx

a. 11xxxxxxxx — b. 1B-35xxxxxxxx

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)