EXAMPLE - AUTHORIZED PHYSICIAN

W900000
WCMed Insurance
16 Avengers Street
White Plains, NY 10604

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 987-65-4321

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 19 1959 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Daily Bugle

5. PATIENT'S ADDRESS (No., Street): 20 Ingram Street

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

7. INSURED'S ADDRESS (No., Street): 1 Firstly Avenue

CITY: Flushing
STATE: NY

8. RESERVED FOR NUCC USE

CITY: New York
STATE: NY

ZIP CODE: 11375
TELEPHONE (Include Area Code): (999) 8887777

ZIP CODE: 10001
TELEPHONE (Include Area Code): (111) 1111111

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: G9000000

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: Parker^^^Peter

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

b. OTHER CLAIM ID (Designated by NUCC): Y4 002288001514WD01

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: WCMed 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 DD YY: 01 12 2020 QUAL. 431

15. OTHER DATE QUAL. 454 MM DD YY: 01 14 2020

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 01 14 2020 TO 01 21 2020

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.
17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
REFX5985555-8B^^^G2OS^^^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. M4726 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	21	20	01	21	20	11		99203		A	142 62	1		OB	985555
															NPI	1777777777
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 987654322 [X]

26. PATIENT'S ACCOUNT NO.: 902620

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

28. TOTAL CHARGE $ 142 62

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.)
Gerry Goblin, MD
SIGNED 01/21/2020 DATE

32. SERVICE FACILITY LOCATION INFORMATION
OSCORP Orthopedic Associates
65 Pennsylvania Circle Ring
Astoria, NY 11104-1699
a. 3777777777 b.

33. BILLING PROVIDER INFO & PH # (222) 2222222
OSCORP Orthopedic Associates
65 Pennsylvania Circle Ring
Astoria, NY 11104-1699
a. 3777777777 b.