EXAMPLE - PT PHYSICIAN'S OFFICE

W900000
WCMed Insurance
16 Avengers Street
White Plains, NY 10604

HEALTH INSURANCE CLAIM FORM

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

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:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 12 2020 QUAL: 431

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Leon Mandrake

17a. 0B 110300

17b. NPI 5999777777

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):
REFX5PT995555-9^^^G2PT^^^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		97110		A	37 91	1		OB	654322
															NPI	2777777778
2	01	21	20	01	21	20	11		97124		A	25 02	1		OB	654322
															NPI	2777777778
3	01	21	20	01	21	20	11		97010		A	5 25	1		OB	654322
															NPI	2777777778
4															NPI	
5															NPI	
6															NPI	

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

26. PATIENT'S ACCOUNT NO.: 902620

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

28. TOTAL CHARGE $ 68 18

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.)
Stan Lee, PT
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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION