SPECIMEN

HEALTH INSURANCE CLAIM FORM

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

PICA

HARROWGATE HEALTH PLAN
CLAIMS DEPARTMENT
PO BOX 18420
CINCINNATI OH 452220420

CARRIER

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) [X] / FECA BLK LUNG (ID#) / OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): HGW418207739
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PELLMONT, MARGARET, L	3. PATIENT'S BIRTH DATE: 04 17 1961 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): PELLMONT, THOMAS, J	
5. PATIENT'S ADDRESS (No., Street): 2418 WILLOW BEND DRIVE	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 2418 WILLOW BEND DRIVE	
CITY: COLUMBUS STATE: OH	8. RESERVED FOR NUCC USE
CITY: COLUMBUS STATE: OH	
ZIP CODE: 43221 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 43221 TELEPHONE (Include Area Code): ( )	
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: OH40372	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 09 02 1959 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: HARROWGATE CHOICE PPO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 10 06 26 QUAL. 431	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. M1711 B. E119 C. I10 D.	23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.	
I. J. K. L.	

PHYSICIAN OR SUPPLIER INFORMATION

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 11 03 26 11 03 26	11		99214	25	ABC	185 00	1		NPI	1742093856
2 11 03 26 11 03 26	11		73562	RT	A	96 50	1		NPI	1742093856
3 11 03 26 11 03 26	11		20610	RT	A	168 00	1		NPI	1742093856
4 N400000418201 ML1 11 03 26 11 03 26	11		J3301		A	30 00	4		NPI	1742093856
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 002936418 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: QFM0047815	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 479 50	29. AMOUNT PAID: $ 30 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.): INES R TALBRIDGE MD SIGNED DATE 110526	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # (614) 5550142 QUARRYBROOK FAMILY MEDICINE 4870 SAWMILL CROSSING RD 210 COLUMBUS OH 432201457 a. 1388046176 b.