LAB CLAIM FORM: REQUIRED FIELDS

HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0123456789

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 28 1945 SEX M ( ) F (X)

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

5. PATIENT'S ADDRESS (No., Street): 625 DAISY STREET

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

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

CITY: PHILADELPHIA | STATE: PA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 19122 | TELEPHONE (Include Area Code): (215) 555-1212

ZIP CODE | 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:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ( ) F ( )

b. RESERVED FOR NUCC USE:

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

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:

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 X DATE 08/26/2022

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 X

PHYSICIAN OR SUPPLIER INFORMATION

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

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: TREATMENT NOW

17a.

17b. NPI: 11234567789

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 ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. ICD-9-M

A. 304.03 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 9090909

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 08 26 2022	09 26 2022	81		85014		A	75 00	5		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 01-2345678

26. PATIENT'S ACCOUNT NO.: LB049C66245A

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

28. TOTAL CHARGE: $ 75 00

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.)

SIGNED X DATE 08/26/2022

32. SERVICE FACILITY LOCATION INFORMATION

TREATMENT NOW
1919 WEST STREET
PHILADELPHIA PA 19101

a. 1123457789 b.

33. BILLING PROVIDER INFO & PH # (215) 555-3434

LABORATORY
101 LEFT STREET
PHILADELPHIA PA 19197

a. 1123456779 b. 103TC0700X