1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY THE NATIONAL UNIFORM CLAIM COMMITTEE 8/05

MEDICARE
PO BOX 3018

Phoenix, AZ 85477

PICA PICA

1. MEDICARE ☑ (Medicare #) MEDICAID ☐ (Medicaid #) Tricare CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hernandez, Jesse J

3. PATIENT'S BIRTH DATE MM DD YY: 05 05 1996 SEX M ☑ F ☐

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

5. PATIENT'S ADDRESS (No. Street): 7932 E. Dynamite Rd.

6. PATIENT'S RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☑ Other ☐

7. INSURED'S ADDRESS (No. Street)

CITY: Peoria STATE: AZ

8. PATIENT'S STATUS: Single ☑ Married ☐ Other ☐

CITY STATE

ZIP CODE: 85383 TELEPHONE (Including Area Code): (623) 5694111

Employed ☑ Full-Time Student ☑ Part-Time Student ☐

ZIP CODE TELEPHONE (Including 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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☑ NO

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☑ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☑ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *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 12112008

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. Charlie Larson

17a.

17b. NPI 8545878565

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☑ NO $ CHARGES 000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE

1. 816.
2. .
3. .
4. .

22. MEDICAID 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	08 15 10	08 15 10	11		99211		1	36 00	1		NPI	1199473014
2	08 15 10	08 15 10	11		73120		1	40 50	1		NPI	1199473014
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 527000000 SSN ☑ EIN ☐

26. PATIENT'S ACCOUNT NO: HERJE000

27. ACCEPT ASSIGNMENT? ☑ YES ☐ NO

28. TOTAL CHARGE $ 76 50

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 76 50

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.)

David Arquette, M.D. 12112010

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Family Medical Center
28000 N Lake Pleasant Rd
Peoria AZ 85383-0222

a. 1199473014 b.

33. BILLING PROVIDER INFO & ph # (623) 4578000

David Arquette M.D.
28000 N. Lake Pleasant Rd.
Peoria AZ 85383-0222

a. 1199473014 b.