1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY THE NATIONAL UNIFORM CLAIM COMMITTEE 8/05

AETNA US HEALTHCARE
PO BOX 14079

SAN FRANCISCO, CA 40512-4079

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) 1525446
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Davis, Annie L	3. PATIENT'S BIRTH DATE MM DD YY 02 08 2002 SEX M ☐ F ☑	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Davis, James P
5. PATIENT'S ADDRESS (No. Street) 8123 W. Pinnacle Peak Rd.	6. PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☑ Other ☐	7. INSURED'S ADDRESS (No. Street) 8123 W. Pinnacle Peak Rd.
CITY: Peoria STATE: AZ	8. PATIENT'S STATUS Single ☐ Married ☑ Other ☐	CITY: Peoria STATE: AZ
ZIP CODE: 85382 TELEPHONE (Including Area Code): (623) 8340477	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 85382 TELEPHONE (Including Area Code): (623) 8340477
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 G89492
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 09 30 1969 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 Intel
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☑ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME AETNA US HEALTHCARE
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 08162007

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 MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. 005.9 3. ____ 2. 787.0 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		99212		12	50 00	1		NPI	1199473014
2	08 15 10	08 15 10	11		81002		12	35 00	1		NPI	1199473014
3	08 15 10	08 15 10	11		99000		12	10 00	1		NPI	1199473014
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 527000000 ☐ ☑	26. PATIENT'S ACCOUNT NO DAVAN000	27. ACCEPT ASSIGNMENT? ☑ YES ☐ NO	28. TOTAL CHARGE $ 95 00
29. AMOUNT PAID $ 0 00	30. BALANCE DUE $ 95 00		

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. 08162010 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & ph # (623) 4578000 Happy Valley Medical Clinic 28000 N. Lake Pleasant Rd. Peoria AZ 85383 a. 1245347880 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-A500 (08-05)