



HEALTH INSURANCE CLAIM FORM

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

☐ PICA										AMERIGROUP STAR KM PO BOX 61117 (For Program in Item 1) VIRGINIA BEACH VA 234661117																																																																															
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐ (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) X X X										3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐										4. INSURED'S NAME (Last Name, First Name, Middle Initial) X X X																																																																					
5. PATIENT'S ADDRESS (No., Street) X X SAVINGS...										6. PATIENT RELATIONSHIP TO INSURED X Self ☐ Spouse ☐ Child ☐ Other ☐ 044 865728 044 865728										7. INSURED'S ADDRESS (No., Street) 610915156																																																																					
CITY HOWARD, NICHOLAS										STATE										CITY HOWARD, NICHOLAS										STATE																																																											
ZIP CODE 4710 SLIDE ROAD										TELEPHONE (Include Area Code) ()										ZIP CODE 4710 SLIDE ROAD										TELEPHONE (Include Area Code) ()																																																											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) LUBBOCK TX										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) ☐ c. OTHER ACCIDENT? ☐ YES ☐ NO										11. INSURED'S POLICY GROUP OR FECA NUMBER LUBBOCK TX																																																																					
a. OTHER INSURED'S POLICY OR GROUP NUMBER 79415										a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ 79415										b. OTHER CLAIM ID (Designated by NUCC) 2YJUD6393HE22																																																																					
b. RESERVED FOR NUCC USE HOWARD, NICHOLAS, 2YX5M72MT171										c. INSURANCE PLAN NAME OR PROGRAM NAME 12 08 1943 X X										c. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.																																																																					
d. INSURANCE PLAN NAME OR PROGRAM NAME SAVINGS...										10d. CLAIM CODES (Designated by NUCC) X X										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.																																																																					
SAVINGS... READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. SAVINGS... 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. MEDICARE PART B SIGNED 755764 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. HEALTH INSURANCE X X SIGNED																																																																															
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 FROM MM DD YY TO MM DD YY																																																																					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Signature On File										17a. 08-24-2022 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY Signature On File																																																																					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 02 02 2021 02 02 1992										20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES 06 13 1987 01 24 2001										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) DN PATRICIA DURHAM NP 1780649632 ICD Ind.																																																																					
22. RESUBMISSION CODE 03 03 2023 ORIGINAL REF 06 03 2023										23. PRIOR AUTHORIZATION NUMBER X X 755 07 988088										24. A. DATE(S) OF SERVICE To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Qual Circumstances) E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.										25. FEDERAL TAX I.D. NUMBER 01 18 22 3 10 22 20 02 99309 02 10 06 01 ABCJ										26. PATIENT'S ACCOUNT NO. 02 99309 02 10 06 01 ABCJ										27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO										28. TOTAL CHARGE \$ 233 00 1 1										29. AMOUNT PAID \$ 1 1										30. Bysd for NUCC Use 363LF0000X 1780649632 363LF0000X									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 820567080 X X										32. SERVICE FACILITY LOCATION INFORMATION 15883542882763 X X										33. BILLING PROVIDER INFO & PH # 133 00 121 71 61 09																																																																					
PATRICIA DURHAM, NP DATE										a. NPI b.										a. NPI b.																																																																					

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION