



NAS-Medicare
 Noridian Administrative Services
 P.O. Box 6727
 Fargo, ND 58108-6727
 Claim Q10378

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																											
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) XXXXXXXXXX																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) XXXXXXXXXX, XXXXX X										3. PATIENT'S BIRTH DATE MM DD YY 10 19 38					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) XXXXXXXXXX, XXXXX X																																																	
5. PATIENT'S ADDRESS (No., Street) 1410 S. Bay Front										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) Same																																																	
CITY Newport Beach					STATE CA					8. RESERVED FOR NUCC USE										CITY					STATE																																												
ZIP CODE 92662					TELEPHONE (Include Area Code) (949) 675-8835															ZIP CODE					TELEPHONE (Include Area Code) ()																																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Same										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER XDO310A63338					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME NAS -Medicare																								
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 03/09/16										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) MM DD YY QUAL:										15. OTHER DATE MM DD YY QUAL:										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 DPM Richie, Douglas										17a. 1013956838										17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R26.9 B. M79.609 C. D. E. F. G. H. I. J. K. L.										22. 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/HCP/CS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										1										2										3										4										5										6									
25. FEDERAL TAX I.D. NUMBER 330838385										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. A13356										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 600 00										29. AMOUNT PAID \$ 00 00										30. Rsvd for NUCC Use 600 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.) Seal Beach Podiatry 3/28/16 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # (562) 493-2453 Seal Beach Podiatry Group 550 Pacific Coast Hwy #209 Seal Beach, CA 90740-6654 a. 1386886018 b.																																																	

Disclaimer: This document does not warrant, verify or guarantee the validity or appropriateness of any of the suggested billing codes. It is not a guarantee of reimbursement for payment. The provider is solely responsible for proper billing of durable medical goods and selection of appropriate codes for reimbursement.