

PLEASE DO NOT STAPLE IN THIS AREA

PROVIDER REMITTANCE ADVICE

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
30XXX

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, John

3. PATIENT'S BIRTHDATE (MM DD YY) SEX
07 04 1952 M

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

5. PATIENT'S ADDRESS (No., Street)
Daytona Beach FL

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

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

8. PATIENT STATUS
Single Married Other

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

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
SUN

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 **01 19 07**

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES
 YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. **723 4** 3. **729 1**
2. **726 10** 4. **728 85**

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

A	B			C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE From DD YY To DD YY	Place of Service	Type of Service									
1	01 19 07	11		97010	1 2 3 4	35 00	1					
2	01 19 07	11		97032	1 2 3 4	40 00	1					
3	01 19 07	11		97035	1 2 3 4	45 00	1					
4	01 19 07	11		L0631	1 2 3 4	1089 00	1					
5												
6												

24. FEDERAL TAX I.D. NUMBER **XXXXXXXXXX** SSN EIN

25. PATIENT'S ACCOUNT NO. **5045 1**

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

27. TOTAL CHARGE \$ **1209 00**

28. AMOUNT PAID \$ **0 00**

29. AMOUNT DUE \$ **1209 00**

30. 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 _____ DATE **011905**

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIN# _____ GRP# _____

SOUTH DAYTONA FL 32119-1861

CHECK DATE 02/03/07	REF # 5XX6 RXM HMX 007 XXX
CHECK NO. XXX95500	AMOUNT \$608.45
TAX ID NO.	

PROV NO. **XX-XXXXX** NAME **MEMBER** UPIN NO. **E6XXX**

NUMBER **XXXXX-301448766-00** ACCOUNT NO. **50XXX**

CLAIM NO. **XXX73647-00** ICD9 DIAG **7234 72610 7291 72885**

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	AMOUNT PAID
97010	01		35.00				35.00	023		.00
97032	01		40.00				40.00	023		.00
97035	01		45.00				45.00	023		.00
L0631	01		1089.00	100.00			380.55	037		608.45

CLAIM TOTAL 1209.00 100.00 500.55 **608.45**

	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	AMOUNT PAID
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PROVIDER TOTAL 1209.00 100.00 500.55 **608.45**

THE ABOVE TOTALS ARE INCLUDED IN CHECK #XXX95500 **608.45**