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|-------------------------------------------------------------------|--|------------------------------------------------|--|------------------------------|--|--------------------------------------------------------------|--|
| 1<br><b>ABC Hospital</b><br>123 M7M Avenue<br>Patterson, LA 70392 |  | 2                                              |  | 3a PAT. CNTL #<br>2323343    |  | 4 TYPE OF BILL<br>112                                        |  |
|                                                                   |  |                                                |  | b. MED. REC. #<br>0064876633 |  |                                                              |  |
|                                                                   |  |                                                |  | 5 FED. TAX NO.<br>711222311  |  | 6 STATEMENT COVERS PERIOD FROM 02/01/2012 THROUGH 02/03/2012 |  |
| 9 PATIENT NAME<br>a. <b>Patterson, Cheryl</b>                     |  | 9 PATIENT ADDRESS<br>a. <b>203 Main Street</b> |  |                              |  |                                                              |  |
| b. <b>Patterson</b>                                               |  | c. <b>LA</b>                                   |  | d. <b>70392</b>              |  | e.                                                           |  |
| 10 BIRTHDATE<br><b>06/03/54</b>                                   |  | 11 SEX<br><b>F</b>                             |  | 12 DATE<br><b>02/01/12</b>   |  | 13 HR<br><b>11</b>                                           |  |
| 14 TYPE<br><b>3</b>                                               |  | 15 SRC<br><b>1</b>                             |  | 16 DHR<br><b>99</b>          |  | 17 STAT<br><b>30</b>                                         |  |
| 18 C1                                                             |  | 19                                             |  | 20                           |  | 21                                                           |  |
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| 87                                                                |  |                                                |  |                              |  |                                                              |  |

UB-04 CMS-1450  
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OMB APPROVAL PENDING

**NUBC** National Union  
Selling Securities LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

\*If Applicable

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

\*If Applicable

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

|                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |
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| PICA                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | PICA                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/><br>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID) |  |  |  |  |  |  |  |  |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)<br><b>1234567890123</b>                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>Lou, Jeannie</b>                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY<br><b>06 19 85</b> SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><br>CITY STATE<br>ZIP CODE TELEPHONE (Include Area Code)<br>( )                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br><br>7. INSURED'S ADDRESS (No., Street)<br><br>CITY STATE<br>ZIP CODE TELEPHONE (Include Area Code)<br>( )                                                                                                                                             |  |  |  |  |  |  |  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br><br>a. OTHER INSURED'S POLICY OR GROUP NUMBER<br><b>TPL Carrier code if applicable</b>                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |  |  |  |
| b. OTHER INSURED'S DATE OF BIRTH<br>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>a. INSURED'S DATE OF BIRTH<br>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| c. EMPLOYER'S NAME OR SCHOOL NAME                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | b. EMPLOYER'S NAME OR SCHOOL NAME                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | c. INSURANCE PLAN NAME OR PROGRAM NAME                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |
| 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.<br><br>SIGNED _____ 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.<br><br>SIGNED _____                                                                                                                                  |  |  |  |  |  |  |  |  |  |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br>MM DD YY                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE<br>MM DD YY                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 17a. <b>PCP Auth # if applicable</b><br>17b. <b>PCP NPI # if Applicable</b>                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 19. RESERVED FOR LOCAL USE                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY<br>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES<br>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER                                                   |  |  |  |  |  |  |  |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)<br>1. <b>V2501</b> 3. _____<br>2. _____ 4. _____                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |
| 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) OPT/HCPCS MODIFIER E. DIAGNOSIS POINTER                                                                                                                                                  |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |
| 1 02 01 12 02 01 12 11 99213 1 75 00 1 NPI 1234567                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 1987654321                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |
| 2 N401234025003 GR150.00 DEPO-PRO VERA INJ 1 90 00 1 NPI 1234567                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 1987654321                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |
| 3                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | NPI                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 4                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | NPI                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 5                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | NPI                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 6                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | NPI                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 26. PATIENT'S ACCOUNT NO. <b>LOU123456</b>                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |
| 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.)<br><b>Ima Biller</b> <b>6/8/11</b>                                                                                                                                    |  |  |  |  |  |  |  |  |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |
| 32. SERVICE FACILITY LOCATION INFORMATION<br>a. <b>NPI</b> b. _____                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 28. TOTAL CHARGE \$ <b>165.00</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>165.00</b>                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| SIGNED _____ DATE _____                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 33. BILLING PROVIDER INFO & PH #<br><b>Womens Health Clinic</b><br><b>985 Bird Rd</b><br><b>Somewhere, LA 70808</b><br>a. <b>1555555551</b> b. <b>1987654</b>                                                                                                                                                      |  |  |  |  |  |  |  |  |  |