-	
	양비
- 20	La.
724	22.00
č	
	2

MDCodeWizard.com

HEALTH INSURANCE CLAIM FORM

				MDG	CodeW	/izard	.com				
Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>	LTH INSURANC	E CLAIM FO	RM								
Machone MEDCANE CHAMPYA Machone Machone <t< th=""><th>VED BY NATIONAL UNIFO</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></t<>	VED BY NATIONAL UNIFO										
Indextant B Operation Dist Non- transmission Non- transmission 123456788 PARTENTS INAME (Last Name, Frex Name, Mode Integ) SXPLINT S BATK MED SSRX 4 SUDJECTS INAME (Last Name, Frex Name, Mode Integ) PARTENTS ADDREES Ro, Steel Is A TATENT REALFOOREHT TO NUMBER Is ATTENT S COUNTION T33 ABC Street Stanta Stanta Rosa CAA R EXEMPTOR FINANCE (Last Name, Mode Integ) Stanta CAA Proce TELEPHONE (Integ A Association) Stanta Reserved FOR NUCC USE CAA Child Reserved FOR NUCC USE CAA RESERVED FOR NUCC USE CA CAA Child R NUMBER'S POLICY OR GROUP NUMBER No Stanta Rosa CAA RESERVED FOR NUCC USE CAA Child R NUMBER'S POLICY OR GROUP NUMBER A UT ACODENT' PURCE Stanta Stanta Rosa CAA RESERVED FOR NUCC USE CA CHILL ACCOUNT NO VIS X NO Is ADMICH ALL NUMBER FOR NUMBER Stanta Rosa Stanta Rosa RESERVED FOR NUCC USE CA CHILL ACCOUNT NO Stanta Rosa Is ADMICH ALL NUMBER FOR NUMAE Stanta Rosa Stanta Rosa RESERVED FOR NUCC USE CA CHILL ACCOUNT NO </th <th></th> <th>7510135</th> <th></th> <th>00000</th> <th>FEOA</th> <th></th> <th></th> <th>1020</th> <th></th> <th></th> <th></th>		7510135		00000	FEOA			1020			
DATENTY SUBJECT DEX A BEX A BEX A BEX DIRITI, JOIN A O 1 1985 W F Smith, JOIN A DIRITIS SUBJECT SUBJECT Smith, JOIN A Smith, JOIN A STATEST SUBJECT SUBJECT Smith, JOIN A Smith, JOIN A STATEST SUBJECT SUBJECT Smith, JOIN A Smith, JOIN A STATEST SUBJECT SUBJECT Smith, JOIN A Smith, JOIN A STATEST SUBJECT SUBJECT Smith, JOIN A Smith, JOIN A STATEST SUBJECT SUBJECT Smith, JOIN A Smith, JOIN A STATEST SUBJECT SUBJE				HEALTH PL	AN BLK LUN	IG		MBER	()	or Program	in item 1)
NUMP. John A O1		13. PATIENT'S BIRT		SEX							
Bart X Sports Child Other 123 ABC Street ITATE A RESERVED FOR NUCC USE ITATE A RESERVED FOR NUCC USE Santa Rosa CA CODE TELEPHONE (include Area Code) GA Santa Rosa CA CODE TELEPHONE (include Area Code) Soft Code TELEPHONE (include Area Code) Status (199) 999-9999 Status Soft Code TELEPHONE (include Area Code) OTHER INSURED'S POLICY OR GROUP NUMBER Is. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY OR GROUP NUMBER IS. IS PATIENT'S CONDITION RELATED TO IS INTERCAME (Law Nume, Frei Name, Made Insue) IS. IS PATIENT'S CONDITION RELATED TO IS INSURANCE PLAN NAME COR PROGRAM NUME EREERVED FOR NUCC USE IS ALTO ACCOENT? PLACE Status IS IS THERE NOT NUME COR PROGRAM NUME IS IS THERE AREA TO PROGRAM NUME IS I				01 01							
Provide STATE R RESERVED FOR NUCC USE CA CODE TELEPHONE (Include Aves Code) Sana Rosa CA CODE TELEPHONE (Include Aves Code) (999) 999-9999 CTHER INCLUES VALUE, LAN INSE, MASSE INSIGN 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY OR GROUP NUMBER II. INSURED'S POLICY OR GROUP NUMBER CTHER INSURED'S POLICY OR GROUP NUMBER II. IS PATIENT'S CONDITION RELATED TO II. INSURED'S POLICY OR GROUP NUMBER II. INSURED'S POLICY OR GROUP NUMBER VES X NO II. INSURED'S POLICY OR GROUP NUMBER II. INSURED'S POLICY OR GROUP NUMBER III. INSURED'S POLICY OR GROUP NUMBER VES X NO YES X NO III. INSURED'S CATE OF BRITH III. INSURED'S CATE OF BRITH VES X NO YES X NO III. INSURED'S CATE OF BRITH III. INSURED'S CATE OF BRITH VESS X NO YES X NO III. INSURED'S CATE OF BRITH III. INSURED'S CATE OF BRITH VESS X NO III. INSURED'S CATE OF BRITH III. INSURED'S CALL OF BRITH INSTRUMER VESS X NO III. INSURED'S CALL OF BRITH INSTRUMER IIII. INSURED'S CALL OF INSTRUMER VESS <td></td> <td></td> <td></td> <td></td> <td colspan="5"></td>											
TODUC TELEPHONE (Indust Avec Cell) TELEPHONE (Indust Avec Cell) 5401 (199) 999-9999 (199) 999-9999 OTHER INSURED'S POLICY OR GROUP NUMBER a: EMPLOYMENT'S CONDITION RELATED TO (1) INSURANCE OF NUMBER a: EMPLOYMENT'S CONDITION RELATED TO RESERVED FOR NUCCU USE a: AUTO ACCIDENT? PLACE (Binith) b: D'THER CAMINE OF PROGRAM NAME F NESERVED FOR NUCCU USE a: AUTO ACCIDENT? PLACE (Binith) b: D'THER CAMINE OF PROGRAM NAME F NESERVED FOR NUCCU USE c: OTHER ACCIDENT? PLACE (Binith) YES NO NISURANCE FLAN NAME OR PROGRAM NAME TO: RESERVED FOR NUCCU USE c: ISTHER ANOTHER HEALTH BENEFIT PLAN? C NUSURANCE FLAN NAME OR PROGRAM NAME TO: RESERVED FOR NUCCU USE c: ISTHER ACCIDENT? C: ISTHER ACCIDENT? c: ISTHER ACCIDENT? PATERSTRING FROM NEEL NUMBER TO: ISTHER DATE TO: ISTHER DATE S: ISTHER DATE F PATERSTRING FROM NEEL NUMBER TO: ISTHER DATE MD D'Y' S: ISTHER DATE S: ISTHER DATE NOUTREST COLUMERT FLINES, NUMBER TO: ISTHER DATE MD D'Y' S: ISTHER DATE S: ISTHER DATE	ABC Street		STATE			Other					STATE
5401 (999) 999-9999 95401 (999) 999-9999 OTHER NOLINED IS NAME (Law Name, First Name, Modile Instein 10. IS PATEENT'S CONDITION RELATED TO 11. IS UPATEENT'S CONDITION RELATED TO 11. IS UPATEENT'S CONDITION RELATED TO OTHER NOLINED S POLICY OR GROUP NUMBER a. EMPLOYMENT (Current or Previous) YS X NO II. IS UPATEENT'S CONDITION RELATED TO RESERVED FOR NUCC USE c. OTHER ACCORDENT? YS X NO II. IS UPATEENT'S CONDITION RELATED TO II. IS UPATEENT'S CONDITION RELATED TO NEEDERVED FOR NUCC USE c. OTHER ACCORDENT? YS X NO III. IS EVERED S AN OTHER ROLLINE (Law ND (Desegnand by NUCC) III. IS UPATEENT'S CONDITION RELATED TO NERVENDENCE OR ALTHOR & BOOMS OF OND MEEORE COMPLETING & BOOMS OF OTHER FORM. VS X NO III. IS UPATEENT BOOMS IN STONTUNE (Law ND (Desegnand by NUCC) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (Desegnand by NUCC) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (DESEGNAL INSER)) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (DESEGNAL INSER)) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (DESEGNAL INSER)) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (DESEGNAL INSER)) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (DESEGNAL INSER)) III. IS UPATEENT BOOMS IN STONTUNE (Law ND (DESEGNAL INSER)) III. IS UPATEENT BOOMS IN CONTRINE (Law ND (DESEGNAL INSER)) IIII. IS UPATEENT BOOMS IN CONTRINE											
Context inscription framework in the service in the bears of the party in the sectors assignment of the											
	77.946	1 ,			CONDITION REL	ATED TO:			Contraction .		19
YES NO M F ESERVED FOR NUCCUSE b. AUTO ACCIDENT? PLACE (Base) b. OTHER CLAIM ID (Designand by NUCC) ESERVED FOR NUCCUSE c. OTHER ACCIDENT? C. NUCRANCE PLAN NAME OR PROGRAM NAME C. NUCRANCE PLAN NAME OR PROGRAM NAME NOURANCE PLAN NAME OR PROGRAM NAME VES X. NO C. NUCRANCE PLAN NAME OR PROGRAM NAME NOURANCE PLAN NAME OR PROGRAM NAME VES X. NO C. NUCRANCE PLAN NAME OR PROGRAM NAME NOURANCE PLAN NAME OR PROGRAM NAME VES X. NO C. NUCRANCE PLAN NAME OR PROGRAM NAME NOURANCE PLAN NAME OR PROGRAM NAME VES X. NO //// Sec.org/noise C. NUCRANCE PLAN NAME OR PROGRAM NAME NOURD ON AUTORIZED PLANCENES COMPLETING & SIGNATURE I JANDRE TO WARDE OF MORTHER NAME OF ORDER OF MORTHER NAME OF ORDER OF MORTHER NAME OF ORDERO OF MORTHER NAME OF ORDERO OF MORTHER NAME OF NOURIENT UNAME OF ORDER NOURIENT ON TO DOUND SIGNAD ONLY IF provider is to receive payment DATE O4/07/2016 NAME OF REFERENCE OR INJURY MAM DD YY Is ADSITUATE UNAME OF ORDERON CURRENT OCCUPATION NAME OF REFERENCE OR INJURY Relate AL to service line below (24E) DUC DUC DUC ADDO VY NO YE SCHARDES NO YE SCHARDES </td <td>HER INSURED S NAME (L</td> <td>at Name, Filst Name, N</td> <td>iddie mital)</td> <td>IU. IS PATIENT S</td> <td>CONDITION REL</td> <td>AILD TO.</td> <td>The mooned of other</td> <td>GROOF GREE</td> <td>-orritoling</td> <td></td> <td></td>	HER INSURED S NAME (L	at Name, Filst Name, N	iddie mital)	IU. IS PATIENT S	CONDITION REL	AILD TO.	The mooned of other	GROOF GREE	-orritoling		
ESSERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Bath) b. CHER CLAIM IN [Designated by NUCC) c. OTHER CLAIM IN[Designated by NUCC] c. OTHER AND LOC USE c. OTHER AND LOCE USE b. COTHER CLAIM IN[Designated by NUCC] c. OTHER AND LOCE USE b. COTHER AND LOCE USE c. OTHER AND LOCE USE b. COTHER AND LOCE USE c. OTHER AND LOCE USE b. COTHER AND LOCE USE c. OTHER AND LOCE USE b. COTHER AND LOCE USE c. OTHER AND THE FORM PATE OF AND LOCE USE c. OTHER AND THE FORM SEGMENT THE SHORE AND MARKED IN HUNDRED PERSIONS SIGNATIVEE I LINKING Degramment of government bandles date to myself or to the party who accepts assignment. BIGNED ON If I provider is to receive payment DATE Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO COLLEGE Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO COLLEGE Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO COLLEGE Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO CURRENT LINKING Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO CURRENT LINKING Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO CURRENT LINKING Catter or CURRENT LINKING, WP REGNANCY (LMP) IS ANTEM THANKED TO CURRENT LINKING Catter or CURRENT LINKING, WP REGNANCY (LMP) IS AND THE AND THANKED CR COTHER HEALTH BENCHARGY <td>HER INSURED'S POLICY</td> <td></td> <td></td> <td>a. EMPLOYMENT?</td> <td>(Current or Previ</td> <td>ous)</td> <td>a. INSURED'S DATE</td> <td>OF BIRTH</td> <td></td> <td>SEX</td> <td></td>	HER INSURED'S POLICY			a. EMPLOYMENT?	(Current or Previ	ous)	a. INSURED'S DATE	OF BIRTH		SEX	
EXERCISE OF REFORMED FOR NUCCUSE EXERCISE OF REFORE COMPLETING & SIGNATURE I WITH A SIGNATURA I WITH A SIGNATURE I WITH A SIGNATURA I WITH A SIGNATURE I WI	CENTER FOR HUGO LIGE			-							F
ESERVED FOR NUCC USE c. OTHER ACCIDENT? c. NURANCE PLAN NAME OR PROGRAM NAME VEURANCE PLAN NAME OR PROGRAM NAME 101. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? READ BACK OF FORM BEFORE COMPLETING & SIGNARD THE FORM. 11. INSURED COR ILLINEST COMPLETING A SIGNARD THE FORM. 11. INSURED COR ILLINEST COMPLETING A SIGNARD THE FORM. ATTENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the reases of any medical or other information necessary. 11. INSURED COR ILLINEST CONTINUE I LINEST. 11. INSURED COR ILLINEST. 11. INSURED COR IL	SERVED FOR NUCC USE						b. OTHER CLAIM ID (D	esignated by NU	CC)		
VES X NO BURANCE PLAN NAME OR PROGRAM NAME 100. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? READ BACK OF FORM BEFORE COMPLETION & SIGNATURE I LIBRORD YES X NO // YES X NO PREAD BACK OF FORM BEFORE COMPLETION & SIGNATURE I LIBRORD YES X NO // YES	SERVED FOR NUCC USE	-		-			C. INSURANCE PLAN N	AME OR PROG	RAM NAME		
NUMBER VES X NO If yes, complete tems 9, 9s and 9d. THEAT TO CALTURATED PERSONS SIGNATURE 1 authorize the release of any medical or other information necessary anows. 13. INSURED'S CALUTERD 2016/001/001/001/001/001/001/001/001/001/						>					
READ DACK OF FORM BEFORE COMPLETING & SIGNING THE FROMM. 13. NOULEED'S OR AUTHORIZED PERSON'S SIGNATURE Lauron and the information measure in a signed of and the information measure infore	INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED F	OR LOCAL USE				FIT PLAN?		
ATTENT OR AUTHORIZED PERSON'S SIGNATURE: I suthing the release of any medical or other information necessary and provider is to receive payment beartly the accepts assignment. payment of medical benefits to the undersigned physician or supple payment. address Donly if provider is to receive payment. DATE: 04/07/2016 SIGNED Only if provider is to receive payment. MUE 07 2016 QUAL MM DD Yr Is DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION ON TO MENT OF MENT OF MENT ON TO MENT OF MENT OF MENT OF MENT OF MENT ON TO MENT OF MENT OF MENT ON TO MENT OF MENT ON TO MENT OF MEN											
BIONED Only if provider is to receive payment DATE 04/07/2016 SIGNED Only if provider is to receive payment ATE OF CURRENT LLNESS, INJURY, or PREGNANCY (LMP) 15.0THER DATE MM DD YY To DD YY AME OF REFERRING PROVIDER OR OTHER SOURCE Ta NAME OF REFERRING PROVIDER OR OTHER SOURCE Ta Is. HOSTILLATION DATES RELATED TO CURRENT SERVICES ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES YES NO J040 B C D 22. PRICE AUTON NUMBER ORIGINAL REF. NO. J040 B C D 22. PRICE AUTON NUMBER ORIGINAL REF. NO. J040 B C D 22. PRICE AUTON NUMBER ORIGINAL REF. NO. J040 B C D D 23. PRIOR AUTHORIZATION NUMBER CODE J040 B C DPROCEDURES, SERVICES, OR SUPPLIES E F. ORIGINAL REF. NO. J040 B C DPROCEDURES, SERVICES, OR SUPPLIES E F. CODE PROVIDENT	TIENT'S OR AUTHORIZED process this claim. I also requ	PERSON'S SIGNATUR	E I authorize the	e release of any medic	al or other inform		payment of medical	benefits to the un	ndersigned p	physician or	supplier for
14 07 2016 QUAL PROM TO NAME OF REFERRING PROVIDER OR OTHER SOURCE 178. 18. HOSPITUL/24TION DATES RELATED TO CURRENT SERVICES PROM TO 18. HOSPITUL/24TION DATES RELATED TO CURRENT SERVICES PROM TO TO ADDITIONAL CLAIM INFORMATION (Designated by NUCO) 20. OUTSIDE LAB? \$ CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. RESUBILISSION ORIGINAL REF. NO. 1040 B C D D 23. PRIOR AUTHORIZATION NUMBER COE # DO YY MM DO YY EMG ORIGINAL REF. NO. 21 PONTEC B C D. D. Z3. PRIOR AUTHORIZATION NUMBER # DO YY MM DO YY EMG ORIGINAL REF. NO. 10 DATE(S) OF SERVICE B C D. D. Z3. PRIOR AUTHORIZATION NUMBER 100 YY MM DO YY BENCE TAILS D. NPI 10 ID ID D. ID N	GNED Only if pro				04/07/2	016					-
UP UP<	Contraction of the second s	and the second sec		1 1	MM DD	YY	MM DD		MM		
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) TO TO TO ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LA9? \$ CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. RESUBINSION ORIGINAL REF. NO. L C								DATES RELATE			/ICES
VES NO DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. RESUMNISSION ORIGINAL REF. NO. L F. G. D. D. 23. PRIOR AUTHORIZATION NUMBER L F. G. H. C. D. J K. L. L. E. F. D. J W. C. MODIFIER S. CHARGES UNTS Bender Structure J VY MM DD VY ScharGes UNTS Bender Structure 20 07 15 12 07 15 11 99213 1 336.30 1 NPI I I INPI INPI INPI INPI INPI INPI I I I INPI INPI INPI INPI I I I I INPI INPI INPI I I I I INPI INPI							1	YY			YY
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) LCD Ind. 22. RESUBMISSION CODE L	DITIONAL CLAIM INFORM	IATION (Designated by	NUCC)				20. OUTSIDE LAB?		\$ CHARGE	s	
J040 B C. D CODE ORGINAL REP. NO. Image: Construct of the statements on the reverse apply to this bill and are made a part thereof.) C. D D CD CODE ORGINAL REP. NO. Image: Construct on the statements on the reverse apply to this bill and are made a part thereof.) C. D. D. D. CODE ORGINAL REP. NO. Image: Construct on the bill and are made a part thereof.) Schwitz Street D. D. CODE ORGINAL REP. NO. Image: Construct on the bill and are made a part thereof.) D. D. D. D. D. D. CODE ORGINAL REP. NO. Image: Construct on the bill and are made a part thereof.) Doe's Family Center D. D. D. D. D. D. D. Review Carter on the reverse apply to this bill and are made a part thereof.) D.	AGNOSIS OR NATURE OF	ILL NESS OR INJURY	Relate A-L to se	arvice line below (24F) ICD lad	1					
F. G. H. 23. PRIOR AUTHORIZATION NUMBER A. DATE(5) OF SERVICE B. C. D.PROCEDURES, SERVICES, OR SUPPLIES E. F. D.O. D.O. PROVIDER IL A. DD YY MM D0 YY B. C. D.PROCEDURES, SERVICES, OR SUPPLIES E. F. D.O. D.O. PROVIDER IL 2 07 15 12 07 15 11 99213 1 1 336.30 1 NPI 2 07 15 12 07 15 11 99213 1 1 336.30 1 NPI 1 1 1 336.30 1 NPI NPI NPI 1 1 1 1 336.30 1 NPI 1 1 1 1 1 1 NPI 1 <					iob iid.)	1	CODE	ORIG	INAL REF. I	NO.	
A DATE(S) OF SERVICE Prom B C. PLACE OF BMG D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPINTER E F. DIAGNOSIS POINTER F. S CHARGES G. ORS H- DIAGNOSIS POINTER I. S CHARGES J. DR. DR. DR. DR. DR. DR. DR. DR. DR. DR			-				23. PRIOR AUTHORIZA	TION NUMBER			
From A To DD YY MM DD YY MAGE of SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS POINTER S CHARGES DAYS UNITS Press POINTER DAYS SCHARGES Press UNITS PROVIDER IT 2 07 15 12 07 15 11 99213 1 336.30 1 NPI 2 07 15 12 07 15 11 99213 1 336.30 1 NPI 1 1 336.30 1 NPI NPI NPI NPI 1 1 28 CATION TON 27. ACCEPT ASSIGNMENT? (For opt claims see back) YES 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 27. ACCEPT ASSIGNMENT? (For opt claims see back) YES X X 33. BILLING PROVIDER INFO & PH # (999) 123-4567 10cutions DEGREES OR CREDENTIALS (Incertify this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION Doe'S Family Center 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567		the second			L. [
2 07 15 12 07 15 11 99213 1 336.30 1 NPI Image: Strain St	From T	O PLACE OF	(Ex	plain Unusual Circum	stances)	DIAGNOSIS	F.	G. H. DAYS EPSDT OR Family			
PEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gort dams, see back) YES X NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gort dams, see back) YES X NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS INCLUDING DEGREES OR CREDENTIALS Doe'S Family Center 987 XWY Street 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (999) 123-4567	DD YY MM D	D YY SERVICE E	MG CP1/HC	PCS MC	DIFIER	POINTER	\$ CHARGES	UNITS Plan	QUAL.	PROVIL	JER ID. #
PEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For goot claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For goot claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Icertify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION Doe'S Family Center 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567	07 15 12 0	7 15 11	9921	3		1	336.30	1	NPI		
NPI NO		1 1 1	1	1 1	1 1	1	1 1 1	1 1	NDI		
REDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 YES X NO s 336.30 s 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.) 32. SERVICE FACILITY LOCATION INFORMATION Doe's Family Center 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567					1 1	1			ALL I		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For goot, damma, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 YES X NO \$ 336.30 \$ 336.30 \$ SIGNATURE OF PHYSICIAN OR SUPPLIER NCLUDING DEGREES OR CREDENTIALS (Locify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION Doe'S Family Center 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567					1 1				NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For goot, damma, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 YES X NO \$ 336.30 \$ 336.30 \$ SIGNATURE OF PHYSICIAN OR SUPPLIER NCLUDING DEGREES OR CREDENTIALS (Locify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION Doe'S Family Center 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567											
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 YES X NO \$ 336.30 \$ 336.30 \$ 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.) 32. SERVICE FACILITY LOCATION INFORMATION 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567									NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 YES X NO \$ 336.30 \$ 336.30 \$ 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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (999) 123-4567									NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE 7654321 X 109486997 YES X NO \$ 336.30 \$ 336.30 \$ 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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (999) 123-4567		1 1 1		1 1	1 1	1	1 1	1 [NPI		
17654321 X 109486997 YES X \$ 336.30 \$ 336.30 \$ 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.) 32. SERVICE FACILITY LOCATION INFORMATION Doe's Family Center 987 XWY Street 33. BILLING PROVIDER INFO & PH # (999) 123-4567	DERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S	ACCOUNT NO.	27. ACCEPT AS	SIGNMENT?	28. TOTAL CHARGE	29. AMO		30. BAL	ANCE DUE
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Doe's Family Center 987 XWY Street 987 XWY Street	654321	×			YES	X NO					0 00
	CLUDING DEGREES OR C certify that the statements of	REDENTIALS	Doe's Fam 987 XWY	nily Center Street	INFORMATION		John Doe 987 XWY Stree	et	(999) 123-45	567
	0/7 0										