

COMMERCE AND INDUSTRY INSATCH- 5001
 1711 US HWY
 PIPESTONE MN 56164

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) CL#709485628	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) NICKEL, CATHY A		3. PATIENT'S BIRTH DATE MM DD YY 09 14 1960 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 606 3 ST SW		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY PIPESTONE STATE MN		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE 56164 TELEPHONE (Include Area Code) (507) 562-3700		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER N/A	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME COMMERCE MANAGEMENT		b. EMPLOYER'S NAME OR SCHOOL NAME COMMERCE MANAGEMENT	
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. SIGNATURE ON FILE DATE 05/14/08		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 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 SMITH, CRAIG M MD		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. ICD E75777		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____	
17b. NPI 1881629202		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____	
19. RESERVED FOR LOCAL USE		23. PRIOR AUTHORIZATION NUMBER _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. L722.10 3. _____		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/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 04 08 08 22 72158 26 1 466.75 1 0B 5386 NPI 1306808720			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER 46-0340989 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 3-808186	
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.) M. Stephen Pardy MD SIGNED 8149 05/14/08		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION AVERA MCKENNAN HOSPITAL 800 E 21ST ST SIOUX FALLS SD 57117		28. TOTAL CHARGE \$ 466.75 29. AMOUNT PAID \$ 0 30. BALANCE DUE \$ 466.75	
33. BILLING PROVIDER INFO & PH. # 605/336-0517		33. BILLING PROVIDER INFO & PH. # 605/336-0517 MEDICAL X-RAY CENTER, P.C. 1417 S MINNESOTA SIOUX FALLS SD 57105	

SECOND FOLD

FIRST FOLD

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION