



HEALTH INSURANCE CLAIM FORM

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

Workers Compensation CO
Corp Management Group
12000 N Washington Street Suite 350
Thornton, CO 80241

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 524919137									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Alarid Vanessa					3. PATIENT'S BIRTH DATE MM DD YY M F <input checked="" type="checkbox"/> 03 12 1994 M F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME									
5. PATIENT'S ADDRESS (No., Street) 2381 W 105th Place					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 Northglenn			STATE CO		8. RESERVED FOR NUCC USE					CITY 			STATE						
ZIP CODE 80234			TELEPHONE (Include Area Code) (720) 421 9589							ZIP CODE			TELEPHONE (Include Area Code)						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M F <input checked="" type="checkbox"/> 03 12 1994 M F <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>									
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										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									
SIGNED DATE 12/26/16										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE QUAL MM DD YY 439 12 26 2016					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					17a.					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
					17b. NPI					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										23. PRIOR AUTHORIZATION NUMBER									
A. S69 91XA B. C. D. E. F. G. H. I. J. K. L.										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/HCPMS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 12 26 16 12 26 16 20 99203 A 170 00 1 NPI 421639127 1730216797										2 12 26 16 12 26 16 20 73130 00 A 122 00 1 NPI 421639127 1730216797									
3 12 26 16 12 26 16 20 Z0750 A 47 00 1 NPI 421639127 1730216797										4 NPI									
5 NPI										6 NPI									
25. FEDERAL TAX I.D. NUMBER 421639127					SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 020001151502					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ 339 00					29. AMOUNT PAID					30. Rsvd for NUCC Use									
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.) Lawson FNP, Sherry 01/02/2017										32. SERVICE FACILITY LOCATION INFORMATION NextCare 121st 4590 W 121st Ave Broomfield CO 80020-5666					33. BILLING PROVIDER INFO & PH # Colorado Urgent Care PLLC PO Box 79576 City Of Industry CA 91716-9576 (480) 776-1600				
SIGNED DATE										a. NPI					b. 1144251976				