

1500

W/C, SUZLON ROTOR CORP  
1711 S US HWY 75  
PIPESTONE, MN 56164

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA -										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 <input checked="" type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>582915474</b>																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>REYES RIVERA, YELISSA IVELISSE</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>10 21 1982</b>					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>REYES RIVERA, YELISSA I</b>																													
5. PATIENT'S ADDRESS (No., Street) <b>1114 7TH AVE</b>										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) <b>1114 7TH AVE</b>																													
CITY <b>WORTHINGTON</b>					STATE <b>MN</b>					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY <b>WORTHINGTON</b>					STATE <b>MN</b>																								
ZIP CODE <b>56187</b>					TELEPHONE (Include Area Code) <b>(507) 727-0544</b>					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										ZIP CODE <b>56187</b>					TELEPHONE (Include Area Code) <b>(507) 727-0544</b>																								
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? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER <b>NONE</b> a. INSURED'S DATE OF BIRTH MM DD YY <b>10 21 1982</b>										SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME <b>W/C, SUZLON ROTOR CORP</b>														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME <b>W/C, SUZLON ROTOR CORP</b>																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER <b>NONE</b>										a. INSURED'S DATE OF BIRTH MM DD YY <b>10 21 1982</b>										SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME <b>W/C, SUZLON ROTOR CORP</b>				
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 <b>SIGNATURE ON FILE</b> DATE <b>05 12 2008</b>										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 <b>SIGNATURE ON FILE</b>																																							
14. DATE OF CURRENT: MM DD YY <b>05 08 2008</b>										ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										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 PROVIDER OR OTHER SOURCE <b>JAMES M DONOHUE, MD</b>										17a. I.D. # <b>IG A02659</b>					17b. NPI <b>1598729550</b>					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
19. RESERVED FOR LOCAL USE <b>Start 1030 Stop 1135 Anesthesia Time 65</b>										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>172743 GANGLION NOS</b>										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																			
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/HCPOS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EFSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #																					
1 <b>05 08 2008 05 08 2008</b>										<b>22</b>		<b>01810 QZ</b>				<b>1</b>		<b>520 00</b>		<b>65</b>		<b>NPI</b>		<b>1780649715</b>																									
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6																				<b>NPI</b>																													
25. FEDERAL TAX I.D. NUMBER <b>41-1638762</b>										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>CB17419</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>520 00</b>					29. AMOUNT PAID \$ <b>0 00</b>					30. BALANCE DUE \$ <b>520 00</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.) <b>CRAIG BERGH, CRNA</b> SIGNED <b>05 13 2008</b> DATE										32. SERVICE FACILITY LOCATION INFORMATION <b>WORTHINGTON REGIONAL HOSPITAL 1018 6TH AVENUE WORTHINGTON, MN 56187</b>										33. BILLING PROVIDER INFO & PH # <b>WORTHINGTON ANESTHESIA SERVICE 400 EAST 10TH STREET WACONIA, MN 55387</b>																													
										a. <b>1396712618</b>					b. <b>1427013812</b>					c. <b>41-1638762</b>																													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER