1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SUZLON ROTOR CO
HWY 75 SOUTH

PIPESTONE, MN 56164

CARRIER

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	TRICARE CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 505114611

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HAGEBOCK, DAVID J	03 21 1983 M ☒ F ☐	SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
5408 S CORMELL PL UNIT 1	Self ☒ Spouse ☐ Child ☐ Other ☐	5408 S CORMELL PL UNIT 1
CITY: SIOUX FALLS / STATE: SD	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY: SIOUX FALLS / STATE: SD
ZIP CODE: 57106 / TELEPHONE (Include Area Code): (605)323-9840	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE: 57106 / TELEPHONE (Include Area Code): (605)323-9840
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: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: SUZLON ROTOR CO
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: OTHER PAYOR-OTHER PAYOR WO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 SIGNATURE ON FILE DATE 11 30 2007

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / 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 MM DD YY FROM / MM DD YY TO
11 12 2007		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1GG35154 / 17b. NPI 1336195643	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
MEYER, JEFFRY D		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES: 000

PLEASE FORWARD TO YOUR WORKCOMP CARRIER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8479
2.
4.

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/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 14 07	11		99213		1	113 00	1		NPI	1336195643
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER / SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
460447693	EP22331400		$ 113 00	$ 0 00	$ 113 00

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (605) 328-9500
JEFFRY D MEYER MD	FAMILY MEDICINE 49TH & OXB 3401 W 49TH ST SIOUX FALLS, SD 57106-232	SANFORD CLINIC PO BOX 5074 SIOUX FALLS, SD 57117-5074
SIGNED 11 30 DATE 2007	a. 1780615112 b.	a. 1255353934 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Transcription	Type	ID	Status	Author
	ProgressNote	1780644	Unsigned	MEYER, JEFFRY D

Transcription Text

Sanford Clinic

Patient Name: HAGEBOCK, DAVID J
DOB: 03/21/1983
Date: 11/14/2007
Record #: 229547-C49S MED-1

SUBJECTIVE: The patient in because he was working the other day and went to lift something, heard something pull and strain at his back and he has had a back pain ever since. He states he has never had back pain before. The pain just stays in his back. Does not radiate down his legs or even into his buttocks. It is mostly right sided but really on both sides. He has been using some ibuprofen and whirlpool bath and really has not gotten much relief.

OBJECTIVE: There is tenderness over the paralumbar spinal musculature especially on the right. There is no pain in the buttocks. Straight leg raise is negative. He has a normal sensory neuro exam in his lower extremities.

ASSESSMENT: Low back strain.

PLAN:
1. Ultram 1 to 2 tablets q. 4 to 6 hours p.r.n. pain maybe take it with Tylenol.
2. I did give him some work restrictions to do for one week. If he is not getting better would then recommend physical therapy consult. If he is getting worse he should followup.

JEFFRY MEYER, M.D./ajo
FAMILY MEDICINE

1780644/1749845
D: 11/14/2007
T: 11/16/2007 08:33:46

cc

PLEASE FORWARD TO YOUR WORKCOMP CARRIER