SCREENING

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA (BLW/VE) OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

9. CITY STATE

8. RESERVED FOR NUCC USE

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. AUTO ACCIDENT?

c. OTHER ACCIDENT?

d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENTS 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 DATE

13. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MP)

14. OTHER DATE QUAL.

15. CLAIM CODES (Designated by NUCC)

16. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

CT01234567

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. DATE(S) OF SERVICE

19. CODES

20. OUTSIDE LAB? 3 CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (2HE)

22. DESENUMERATION CODE

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT TO GO THROUGH THE PROCESS

28. TOTAL CHARGE

29. AMOUNT PAID

30. Resid for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If you 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 #

Dr. B

NPI

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)
<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Code</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG</td>
<td>93005Q1</td>
<td>122416</td>
</tr>
<tr>
<td>CT</td>
<td>71260Q1</td>
<td>122416</td>
</tr>
<tr>
<td>BUN</td>
<td>84520Q1</td>
<td>122416</td>
</tr>
<tr>
<td>CREATININE</td>
<td>82565Q1</td>
<td>122416</td>
</tr>
<tr>
<td>FULL BODY BONE SCAN</td>
<td>78300Q1</td>
<td>122416</td>
</tr>
<tr>
<td>CONTRAST</td>
<td>A9503Q1</td>
<td>122416</td>
</tr>
</tbody>
</table>

**Screening**
<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
<td>Medicare Advantage Z00.6</td>
</tr>
<tr>
<td>4. INSURED’S NAME</td>
<td>John Doe</td>
</tr>
<tr>
<td>5. PATIENT’S ADDRESS</td>
<td>123 Maple St, Anytown, USA</td>
</tr>
<tr>
<td>10. IS PATIENT’S CONDITION RELATED TO: EMPLOYMENT?</td>
<td>Yes</td>
</tr>
<tr>
<td>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY</td>
<td>01/03/17</td>
</tr>
<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>Jane Smith, MD</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>Z00.6</td>
</tr>
<tr>
<td>24. A. DATE(S) OF SERVICE</td>
<td>01/03/17</td>
</tr>
<tr>
<td>25. FEDERAL TAX ID NUMBER</td>
<td>123456789</td>
</tr>
<tr>
<td>29. PATIENT’S ACCOUNT NO.</td>
<td>123456789</td>
</tr>
<tr>
<td>30.渲染供应商ID#</td>
<td>A0001</td>
</tr>
<tr>
<td>31. 签名</td>
<td>医疗提供者签名</td>
</tr>
<tr>
<td>32. SERVICE FACILITY LOCATION INFORMATION</td>
<td>兼容性测试实验室</td>
</tr>
<tr>
<td>33. BILLING PROVIDER INFO &amp; PH #</td>
<td>医疗提供者信息及电话</td>
</tr>
<tr>
<td>34. NPI</td>
<td>医疗提供者标识号</td>
</tr>
</tbody>
</table>

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0938-1197 FORM 1500 (02-12)**

**NUCC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)
<table>
<thead>
<tr>
<th>Occurrence Code</th>
<th>Occurrence Date</th>
<th>Occurrence Code</th>
<th>Occurrence Date</th>
<th>Occurrence Code</th>
<th>Occurrence Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4</td>
<td>010317</td>
<td>D4</td>
<td>010517</td>
<td>D4</td>
<td>010517</td>
</tr>
</tbody>
</table>

**Office Visit**

- **Office Visit**
  - Code: G0463Q1
  - Date: 010317

**Chemotherapy Administration Initial**

- **Chemotherapy Administration Initial**
  - Code: 96413Q1
  - Date: 010517

**Chemotherapy Administration, Additional HR**

- **Chemotherapy Administration, Additional HR**
  - Code: 96415Q1
  - Date: 010517

**Drug #2**

- **Drug #2**
  - Code: J9045Q1
  - Date: 010517

**Drug #3**

- **Drug #3**
  - Code: J9264Q1
  - Date: 010517
C2D3 - ARM B

MEDICARE ADVANTAGE

Z00.6

85025  020217

VENIPUNCTURE  36415  020217

CBC

CHEST X-RAY  71020  020217
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>7126026Q1</td>
<td>080117</td>
</tr>
<tr>
<td>CONTRAST</td>
<td>Q9967Q1</td>
<td>080117</td>
</tr>
</tbody>
</table>