HEALTH INSURANCE CLAIM FORM

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

PPP PICA 26 CHARITY

CHARITY/INDIGENT CARE-INOVA
EXEC ASSISTANT-AVP PATIENT FIN
2990 TELESTAR COURT-3RD FLOOR
FALLS CHURCH VA 22042-1207 Status 1

PICA

CARRIER

1. MEDICARE ( ) (Medicare #) MEDICAID ( ) (Medicaid #) TRICARE ( ) (ID#/DoD#) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (ID#) FECA BLK LUNG ( ) (ID#) OTHER (X) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 10104410486

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): VASQUEZ CHANEZ CARLA A

3. PATIENT'S BIRTH DATE MM DD YY: 09 13 1981 SEX M ( ) F (X)

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

5. PATIENT'S ADDRESS (No., Street): 7209 BONA VISTA COURT

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: SPRINGFIELD STATE: VA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 22150 TELEPHONE (Include Area Code): (703)372-5348

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) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY: 09 13 1981 SEX M ( ) F (X)

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME: CHARITY/INDIGENT CARE-INOVA

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) If yes, complete items 9, 9a and 9d.

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 12-07-2017

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 12 07 2017 QUAL 431

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN JILL B WATRAS, M.D.

17a.

17b. NPI 1023224284

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 07 2017 TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ( ) NO (X) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. K85 90 B. K80 50 C. K83 1 D.
E. F. G. H.
I. J. K. L.

22. 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 12 07 2017	12 07 17	21		99222	25	ABC	250 00	1		NPI	1649255233
2 12 07 2017	12 07 17	21		43264		ABC	940 00	1		NPI	1649255233
3 12 07 2017	12 07 17	21		43262		ABC	600 00	1		NPI	1649255233
4 12 07 2017	12 07 17	21		74360	26	ABC	180 00	1		NPI	1649255233
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 54-0892627 EIN (X)

26. PATIENT'S ACCOUNT NO.: 232546

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES (X) NO ( )

28. TOTAL CHARGE: $ 1970 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.)

MAHMOOD ABEDI, M.D.
12-12-2017
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

INOVA FAIRFAX HOSPITAL
3300 GALLOWS ROAD
FALLS CHURCH VA 22042-3300

a. 1831220714 b.

33. BILLING PROVIDER INFO & PH. # ( )

GASTROENTEROLOGY ASSOCIATES OF
3700 JOSEPH SIEWICK #308 SUITE 308
FAIRFAX VA 22033-1739

a. 1205884368 b.

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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