Status 2

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INDIGENT CARE FUND
2990 TELESTAR COURT
FALLS CHURCH, VA 22042

Humana
medicare PPO

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 226663315 H683958301020200982O

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)
ANDERSON, ROBERT M	06 04 47 M X F	ANDERSON ROBERT M

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
176 DOC STONE ROAD	Self X Spouse Child Other	SAME

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
STAFFORD	VA			

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
22556	(571) 2967323		( )

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 / SEX M F
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: INDIGENT CARE FUND
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 10132017

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 QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 13 17 TO 10 13 17
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. I50.9	B. I48.91	C. J44.1	D. N17.9
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 10 13 17	10 13 17	21		99291		ABCD	343 00	1		NPI	N5562419946 1336212141
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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
562419946 X	546307959	YES X NO	$ 343 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 # (571) 455-3966
RASHID NAYYAR M.D.	INOVA ALEXANDRIA HOSPITAL	RASHID NAYYAR M.D.
101231228 10162017	4320 SEMINARY RD	6247 ROLLING SPRING CT
SIGNED DATE	ALEXANDRIA, VA 223041535	SPRINGFIELD VA 221522242
	a. 1457538191 b.	a. 1336212141 b. G2562419946

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION