PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 11-2234-10190

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

3. PATIENT'S BIRTH DATE MM DD YY: SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Any Street

CITY: Any City STATE: CA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Any City STATE: CA

ZIP CODE: 92127 TELEPHONE (Include Area Code): (858) 555-0100

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 92127 TELEPHONE (INCLUDE AREA CODE): (858) 555-0100

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: G4683A

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: 06 12 65 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Group Insur of Amer.

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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: JDoe DATE: 01-15-2021

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: JaneDoe

14. DATE OF CURRENT: MM DD YY: 10 11 21 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 11 21

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Self

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. R11.0
2. K59.00
3. R19.7
4. K92.1

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	11	21				11		90801			170.00					1234567890
2 10	11	21				11		90805			140.00					1234567890
3 10	11	21				11		90812			93.00					1234567890
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [X] EIN [ ]: 555-88-9999

26. PATIENT'S ACCOUNT NO.:

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

28. TOTAL CHARGE: $ 405.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

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.)

SIGNED: MtJackson DATE: 10/11/21

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Mateo Jackson PhD
9876 Healthcare Ave
Any Town, CA 92126

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Mateo Jackson PhD
9876 Healthcare Ave (920) 555-0101
Any Town, CA 92126

PIN#: GRP#:

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Not a Memorial Hospital
Of Collier
Reg: PN/S/11011, Non-Profit
Contact: (999)-(888)-(1234)

Physician Hospital Discharge Summary

Provider: Mateo Jackson, Phd

Patient: John Doe **Provider's Pt ID:** 00988277891 **Patient Gender:** Male

Attachment Control Number: XA/7B/00338763

Visit (Encounter)

Admitted: 07-Sep-2020 **Discharged:** 08-Sep-2020

Discharged to: Home with support services

Assessment

Reported Symptoms / History of present illness:

35 yo M c/o stomach problems since 2 montsh ago. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermitent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exhacerbates pain. Pain unrelated to daytime or to meals. Patient denies constipation or diarrhea. Patient denies blood in stool but have noticed them darker. Patient also reports nausea. Denies recent illness or fever. He also reports fatigue since 2 weeks ago and bloating after eating.
Patient ID: NARH-36640
ROS: Negative except for above findings
Meds: Motrin once/week. Tums previously.
PMHx: Back pain and muscle spasms. No Hx of surgery. NKDA.
FHx: Uncle has a bleeding ulcer.
Social Hx: Smokes since 15 yo, 1/2-1 PPD. No recent EtOH use. Denies illicit drug use. Works on high elevation construction. Fast food diet. Exercises 3-4 times/week but stopped 2 weeks ago.

Discharge

Discharge Studies Summary:

Some activity restrictions suggested, full course of antibiotics, check back with physican in case of relapse, strict diet

VS/3S/Q990-7550/1090001004290

Attending Provider Notes

Provider: Dr Mateo Jackson, PhD

Patient: John Doe

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35 yo M c/o stomach problems since last 2 months. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermittent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exacerbates pain. Pain unrelated to daytime or to meals. Patient denies constipation or diarrhea. Patient denies blood in stool but have noticed them darker. Patient also reports nausea. Denies recent illness or fever. He also reports fatigue in the last 2 weeks ago and bloating after eating.

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