HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ | PICA ☐☐☐

1. MEDICARE ☐ (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)

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. PATIENTS ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY | STATE: CA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY | STATE: CA

ZIP CODE | TELEPHONE (Indude Area Code): ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): n/a

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: n/a

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: n/a DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME: n/a

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: n/a

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, retum to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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. INSURED'S OR AUTHORIZED PERSON S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

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

15. IF PATENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: n/a

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: n/a

17 . I.D. NUMBER OF REFERRING PHYSICIAN: n/a

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ n/a

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

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE: n/a ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: n/a

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	DAYS OR UNITS	EPSDT family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1		1	OV									
2			OV									
3			OV									
4			OV									
5			OV									
6			OV									

25. FEDERAL TAX I.D. NUMBER SSN EIN: tax id.#:33-0386994 ☐ ☒

26. ACCOUNT NO.

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

28. TOTAL CHARGE $

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 DATE

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

office

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

Leslie M. Drozd, Ph.D.
1001 Dove St., Ste. 110
Newport Beach, CA 9266 0

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8188) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938 0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB4720-0001 (CHAMPUS)