MDCodeWizard.com

Aetna
PO Box 981106
El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

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): XA10966343
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John				3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1995 SEX M X F			4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John
5. PATIENT'S ADDRESS (No., Street): 123 Apple Street				6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other			7. INSURED'S ADDRESS (No., Street): 123 Apple Street
CITY: Los Angeles		STATE: CA		8. RESERVED FOR NUCC USE			CITY: Los Angeles / STATE: CA
ZIP CODE: 90049	TELEPHONE (Include Area Code): (310) 555-1212						ZIP CODE: 90049 / TELEPHONE (Include Area Code): (310) 555-1212
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
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			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 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 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. / 71b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO X $ CHARGES: 0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. F33.2 B. C. D. E. F. G. H. I. J. K. L.		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. 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 04 03 18 04 03 18	11	--	90868	- - - -	A	475 00	1	-		A99637
1 04 03 18 04 03 18	11	--	90868	- - - -	A	475 00	1	-	NPI	1437303708
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. BALANCE DUE
753261628	X		YES NO X	$ 475 00	$ 475 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 # (310) 440-9800
SIGNED M Mamoun MD DATE 91918	CNS Health 2811 Wilshire Blvd #790 Santa Monica, CA 90403 a. 1437303708 b. 75-3261628	CNS Health 2811 Wilshire Blvd #790 Santa Monica, CA 90403 a. 1437303708 b.