

1500

2080470
CRANIOFACIAL AND CLEFT PALATE CLIN
3601 WEST THIRTEEN MILR ROAD ROOM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

ROYAL OAK, MI 48073

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																																									
1. MEDICARE <input type="checkbox"/> (Medicare #)					MEDICAID <input type="checkbox"/> (Medicaid #)					TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)					FECA BLK LUNG <input type="checkbox"/> (SSN)					OTHER <input checked="" type="checkbox"/> (ID)																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHUBANYUK DENIS Y										3. PATIENT'S BIRTH DATE 10 28 2010										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																																																																															
5. PATIENT'S ADDRESS (No., Street) 42843 POTOMAC										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 42843 POTOMAC																																																																															
CITY NOVI					STATE MI					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY NOVI					STATE MI																																																																															
ZIP CODE 48375 1769					TELEPHONE (Include Area Code) (734) 846-2759					Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 48375-1769					TELEPHONE (Include Area Code) (734) 846-2759																																																																															
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 NONE																																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																															
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME OTHER PAYOR-OTHER PLAN																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																															
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 09 26 2012										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: MM DD YY					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE FISHMAN, JEFREY R					17a. IGF01721					17b. NPI 1144238593					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																				
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 755 12										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										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1 08312012										21										26562										F6										1										2410 00 1																				NPI 1144238593																													
2 08312012										21										26562										59 F9										1										2410 00 1																				NPI 1144238593																													
3 08312012										21										26562										59 F1										1										2410 00 1																				NPI 1144238593																													
4 08312012										21										26562										59 F4										1										2410 00 1																				NPI 1144238593																													
5																																																																						NPI																													
6																																																																																NPI																			
25. FEDERAL TAX I.D. NUMBER 383085591										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. Q05712120										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 9640 00										29. AMOUNT PAID \$ 0 00										30. BALANCE DUE \$ 9640 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.) JEFREY R FISHMAN MD										32. SERVICE FACILITY LOCATION INFORMATION PRAC MGMT FOR BEAUMONT RO 3601 W THIRTEEN MILE RD ROYAL OAK MI 48073 6712										33. BILLING PROVIDER INFO & PH # (248) 643-7374 JEFREY R A FISHMAN M D 1777 AXTELL DR STE 2 TROY MI 48084 4435																																																																															
SIGNED 09 26 2012 DATE										a.1689653305										b.										a.1932376993										b.																																																											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER