

PRUDENTIAL INSURANCE COMPANY
976 SEVENTH ST
DUBUQUE, IA 52001

EMPL: TEL-WORLD TRAVEL
4366 WASHINGTON AVE
SUITE 104
DES PLAINES, IL 60018

PATIENT NUMBER: 4-451-548

HEALTH INSURANCE CLAIM FORM

MCA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURER'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 372-71-7772-01	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COOPER, MARIA E		4. INSURED'S NAME (Last Name, First Name, Middle Initial) COOPER, ADAM M	
3. PATIENT'S BIRTHDATE MM : DD : YY 08 : 24 : 60 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		5. INSURED'S ADDRESS (No. Street) 512 CORDIAL DRIVE	
5. PATIENT'S ADDRESS (No. Street) 512 CORDIAL DRIVE		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) 512 CORDIAL DRIVE	
7. CITY DES PLAINES STATE IL		8. CITY DES PLAINES STATE IL	
8. ZIP CODE 60018 TELEPHONE (Include Area Code) ()		9. ZIP CODE 60018 TELEPHONE (INCLUDE AREA CODE) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM : DD : YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER 482391-A	
4. INSURANCE PLAN NAME OR PROGRAM NAME		a. INSURED'S DATE OF BIRTH MM : DD : YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 05 : 31 : 50	
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. SIGNATURE ON FILE DATE 06-04-2002		b. EMPLOYER'S NAME OR SCHOOL NAME ACME ROOFING	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE		c. INSURANCE PLAN NAME OR PROGRAM NAME PRUDENTIAL BASIC	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM : DD : YY		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # yes, return to and complete item 9 a-d.	
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 PHYSICIAN OR OTHER SOURCE		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	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V04.8		22. MEDICADA RESUBMISSION CODE ORIGINAL REF. NO.	
2. _____ 3. _____		23. PRIOR AUTHORIZATION NUMBER	
24. A B C D E F G H I J K DATES(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EP/SOT Family Plan EMG COB RESERVED FOR LOCAL USE		25. FEDERAL TAX I.D. NUMBER 33H EIN 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gen. claims, see back) 29. AMOUNT PAID 30. BALANCE DUE	
06 : 04 : 02 06 : 04 : 02 03 01 99212 1 25 00 1		86-1289320 <input checked="" type="checkbox"/> 33-33440 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ 35 : 00 \$ 0 : 00 \$ 35 : 00	
06 : 04 : 02 06 : 04 : 02 03 01 90737 1 10 00 1		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) SIDNEY FOSTER, M.D. DATE 06-04-2002	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # WESTSIDE MEDICAL CLINIC 3200 N CENTRAL AVE PHOENIX, AZ 85012 (602) 230-7575	
SIGNED _____		PIN# _____ GRP# _____	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

Figure 12-3. HCFA-1500 (12-90) insurance claim