Pennsylvania Access (Medicaid)
PO Box 8194
Harrisburg, PA 17106

HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE ☐ (Medicare #) MEDICAID ☑ (Medicaid #) TRICARE ☐ (ID#/DOD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
0013033256

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
TEST , 12345 ,

3. PATIENT'S BIRTH DATE MM 01 DD 08 YY 2009 SEX M ☐ F ☑

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
TEST , 12345 ,

5. PATIENT'S ADDRESS (No., Street)
2004 RTE 17M

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

7. INSURED'S ADDRESS (No., Street)
2004 RTE 17M

CITY
GOSHEN

STATE
NY

8. RESERVED FOR NUCC USE

CITY
GOSHEN

STATE
NY

ZIP CODE
10924

TELEPHONE (Include Area Code)
(999) 999 - 9999

ZIP CODE
10924

TELEPHONE (Include Area Code)
(999) 999 - 9999

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
TEST 12345

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
0013033256

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

a. INSURED'S DATE OF BIRTH MM 01 DD 08 YY 2009 SEX M ☐ F ☑

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☑

c. INSURANCE PLAN NAME OR PROGRAM NAME
Pennsylvania Access (Medicaid)

d. INSURANCE PLAN NAME OR PROGRAM NAME
Pennsylvania Access (Medicaid)

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☑ NO ☐ 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 Signature on File 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 Signature on File

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.

17b. 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 ☑ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. A15.8 B. A18.03 C. B02.21 D. B55.2
E. D72.12 F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1														1D	1031463060001
	12	05	2022	12	05	2022	11		31231	A	587.61	1		NPI	1234567890
2														1D	1031463060001
	12	05	2022	12	05	2022	11		92557	B	115.23	1		NPI	1234567890
3														1D	1031463060001
	12	05	2022	12	05	2022	11		92567	C	50.88	1		NPI	1234567890
4														1D	1031463060001
	12	05	2022	12	05	2022	11		95117	D	35.31	1		NPI	1234567890
5														1D	1031463060001
	12	05	2022	12	05	2022	11		95004	59 E	12.45	1		NPI	1234567890
6														1D	1031463060001
														NPI	1234567890

25. FEDERAL TAX I.D. NUMBER SSN EIN
141533671 ☑

26. PATIENT'S ACCOUNT NO.
19362511

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

28. TOTAL CHARGE
801.48

29. AMOUNT PAID
$ 0

30. Rsvd for NUCC Use

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.)
PROVIDER LEMUEL
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
WRS HEALTH TRAINING
2004 ROUTE 17M
GOSHEN NY 10924-5210
a. 1234567890 b

33. BILLING PROVIDER INFO & PH # (866 977 4367
WRS HEALTH TRAINING
2004 ROUTE 17M
GOSHEN NY 10924-5210
a. 1023478351 b

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION