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BLUE SHIELD OF CALIFORNIA
P O BOX 272540
CHICO CA 95927-2540

HEALTH INSURANCE CLAIM FORM

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

PICA ☐		PICA ☐	
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) XTP8003216134	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOMBARDI JULIA M		3. PATIENT'S BIRTH DATE MM DD YY 11 22 1776 M ☐ F ☒	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) LOMBARDI ANTHONY P		5. PATIENT'S ADDRESS (No., Street) 2112 GARDEN AVENUE	
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☒ Other ☐		7. INSURED'S ADDRESS (No., Street) SAME	
CITY TEMECULA		STATE CA	
8. RESERVED FOR NUCC USE		CITY	
STATE CA		STATE	
ZIP CODE 92590		TELEPHONE (Include Area Code) (951) 555-3321	
ZIP CODE		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) ☐ YES ☒ NO b. AUTO ACCIDENT? ☐ YES ☒ NO c. OTHER ACCIDENT? ☐ YES ☒ NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER 30153		a. INSURED'S DATE OF BIRTH MM DD YY 06 25 1975 M ☒ F ☐	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a and 9d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		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	
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 05152014	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
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 17a. 17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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) A. K50.90 B. L02.411 C. D. E. 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 05 15 14 11 99213 A 100 00 1 NPI 2014536798		2 05 15 14 11 10060 B 200 00 1 NPI 2014536798	
3		4	
5		6	
25. FEDERAL TAX I.D. NUMBER SSN EIN ☒		26. PATIENT'S ACCOUNT NO. JL2124	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO		28. TOTAL CHARGE \$ 300 00	
29. AMOUNT PAID \$		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.) CONSTANCE WILKINS, MD		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	
33. BILLING PROVIDER INFO & PH # (951) 555-3030 RIVERSIDE FAMILY PRACTICE 2014 PROFESSIONAL DRIVE TEMECULA CA 92590		a. 1978145730 b.	
SIGNED DATE 05142014R			