



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 1976 M ☐ F ☒ SEX	
5. PATIENT'S ADDRESS (No., Street) 2112 GARDEN AVENUE		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☒ Other ☐	
CITY TEMECULA		CITY TEMECULA	
STATE CA		STATE CA	
ZIP CODE 92590		ZIP CODE 92590	
TELEPHONE (Include Area Code) (951) 555-3321		TELEPHONE (Include Area Code) (951) 555-3321	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? ☐ YES ☒ NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER 30153		11. INSURED'S DATE OF BIRTH MM DD YY 06 25 1975 M ☒ F ☐ SEX	
a. OTHER CLAIM ID (Designated by NUCC)		b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME BLUE SHIELD OF CALIFORNIA		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a and 9d.	
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		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 MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		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? \$ CHARGES ☐ YES ☐ NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. K50.90 B. L02.411 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To 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 25 A 100 00 1 NPI 2014536798			
2 05 15 14 11 10060 25 B 200 00 1 NPI 2014536798			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 95-5290246 ☐ ☒		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	
33. BILLING PROVIDER INFO & PH # (951) 555-3030 RIVERSIDE FAMILY PRACTICE 2014 PROFESSIONAL DRIVE TEMECULA CA 92590			
SIGNED SOF DATE 05142014		a. NPI b. 1978145730	