



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

PICA ☐ ☐ ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN (ID#) ☒ FECA BLK LUNG (ID#) ☐ OTHER (ID#) ☐		1a. INSURED'S I.D. NUMBER XTP800321613475	
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 ☒	
5. PATIENT'S ADDRESS (No., Street) 2112 GARDEN AVENUE		7. INSURED'S ADDRESS (No., Street) 2112 GARDEN AVENUE	
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)		11. INSURED'S POLICY GROUP OR FECA NUMBER 30153	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY 06 25 1975 M ☒ F ☐	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME Insurance company	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a and 9d.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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.		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 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) A. K50.90 B. I02.411 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		25. FEDERAL TAX I.D. NUMBER SSN EIN Input ein numbers ☐ ☒	
26. PATIENT'S ACCOUNT NO. JL2124		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	
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		30. Rsvd for NUCC Use	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION