

Client Registration Form

CLIENT INFORMATION

Client's Name:	
Preferred Name:	Date of Birth:
Social Security Number:	_ Male 🗌 Female 🗌
Street Address:	
City:	
Home Phone #:	Name listed under?
Mobile Phone #:	Name listed under?
Client lives with:	Relationship to Client:
If applicable, Client is in legal custody of:	Full 📋 Joint 🗌
Father's name:	Mother's name:
Stepfather's name:	Stepmother's name:

RESPONSIBLE PARTY/GUARANTOR

The Responsible Party/Guarantor for your family's account is the person responsible for paying the bill. This may or may not be the person who holds the health insurance policy. Clients under age of 18 may not be guarantors for their medical bills. In the case of separated or divorced parents, the parent/legal guardian who brings the minor in for treatment is the guarantor for any charges incurred. The only way that this situation may be changed is if the practice is given copies of a court order that states another party is responsible for medical bills.

Responsible Party/Guarantor:			
Street Address:			
City:		State: Zip:	
Home Phone #:	Cell #:	Work #:	
Social Security Number:		Employed By:	



HEALTH INSURANCE INFORMATION

PRIMARY:	SECONDARY:
Subscriber's Name:	Subscriber's Name:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Relation to Client:	Relation to Client:
Member ID Number:	Member ID Number:
Group Number:	Group Number:

PLEASE LET US KNOW TODAY if you are using your EAP for your initial visits. Yes No

If Yes, insurance name & authorization #: ____

HEALTH INSURANCE/BILLING/FINANCIAL POLICY

We are committed to providing you with the best possible care. If your insurance has **coverage for mental health, occupational therapy, physical therapy, and/or speech therapy** we anticipate helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

- 1. Your insurance is a contract between you and your employer and the insurance company. We are not a party to that contract.
- 2. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- 3. The Therapy Tree, LLC is NOT responsible for keeping up with your insurance company's deductible, co-pays, co-insurance and/or the number of visits authorized by your insurance.
- 4. Co-payments, Co-Insurance, and Deductibles must be paid at the time of service.
- 5. If you do not have insurance or if your services are not covered by insurance, payment for service is due at the time of service *unless* payment arrangements have been approved in advance by our staff. We accept cash, checks, MC, VISA, Discover, and Care Credit.

We must emphasize that as Providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our clients, all charges are your responsibility from the date the services are rendered and are to be paid in full within 90 days. We realize that temporary financial problems may arise and we encourage you to contact us promptly for assistance in management of your account.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health, speech, occupational, and physical therapy services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some Clients feel that they need more services after insurance benefits end. At this point, the client will be required to be put on hold or to pay a reduced



out of pocket fee at the time of service unless other arrangement are made in advance of the first non-covered session.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer or cloud. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, and the accompanying Authorization, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

PROFESSIONAL FEES

Counseling - During the initial consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 45-60 minutes. Longer or shorter visits may be scheduled at times.

Initial consultation session is \$140 Individual 45 minute session is \$140 Individual 60 minute session is \$186.66 Family 45-60 minute session is \$155 An additional \$30/session may be charged depending on complexity

Speech - During the consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 30-60 minutes. Longer or shorter visits may be scheduled at times.

Initial consultation, assessment and evaluation is \$360 30 minute session is \$100 45 minute session is \$150 60 minute session is \$200

OT/PT - During the consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 30-60 minutes. Longer or shorter visits may be scheduled at times.

Initial consultation, assessment and evaluation is \$360 30 minute session is \$90 45 minute session is \$135 60 minute session is \$180

Other fees:

1. Telephone consultations with you, or on your behalf, may be billed at a rate proportionate to the rate for therapy. Written communications to you or on your behalf will also be billed at a similar rate (e.g. letter preparation or email consultation).



- 2. The fee for returned checks is \$30.00.
- 3. Any court appearance, or deposition, or the provision of documents for any attorney or for the court will be billed at a rate of \$200 per hour, and will include preparation and travel time. Insurance does not cover these services. You may be asked to pay for time reserved in advance or pay a retainer, either of which is necessary before the court appearance or deposition can occur.
- 4. School IEP meeting attendance is billed at a rate of \$75 per hour and will include preparation and travel time. The Therapy Tree does not bill insurance for attendance at IEP meetings.

Payment is due at the time of service. We accept VISA, MasterCard, Discover, check and cash. If you have and are using insurance coverage, you MUST call to verify coverage, obtain pre-authorization (if required) and verify your co-pay amount and deductible remaining before the first visit, or you will be asked to pay full fee for the first visit.

Fees are subject to change at any time with or without prior notice.

CANCELLATION POLICY

As therapists, we work as service providers. Therefore, our only commodity is our time (and expertise). A scheduled appointment is like a contract: the client has hired us to provide our undivided attention during a specified period of time. When someone fails to appear for a scheduled appointment, we are not able to fill in that time with another client. When appointments are cancelled less than 24 hours before the appointment, we likewise may not be able to fill the time. Therapists needing to cancel their scheduled appointments with families will also provide 24 hours' notice prior to appointment when possible.

The Therapy Tree may charge a cancellation fee of \$30 per missed session, and has the option of terminating services following three missed appointments. We cannot bill your insurance company for a missed appointment.

Illness - If you or your child has any of the following symptoms, treatment should be canceled. This also applies if any members of the household show these symptoms when the therapist provides treatment in the home.

- Fever of 100 degrees or higher, diarrhea, or vomiting within 24 hours of treatment time.
- Serious sneezing or coughing, especially with mucous present.
- Watering/mattering eyes, discharge from ears.
- Runny nose when discharge is NOT clear.
- When child or member of household is exposed to serious childhood illnesses like chicken pox, measles, hand/foot/mouth disease, RSV, etc.
- Unusual spots, rashes, or bruises not associated with injury.
- Sore throat or difficulty swallowing.
- Unusual behavior, child does not feel well enough to participate in normal activities.

Weather – In case of inclement weather, please call the office main line at 847-265-7300. A message will be recorded announcing if clinic is closed due to weather. Typically, if Lake Villa/Lindenhurst School District #41 is closed due to weather, then The Therapy Tree may also close. Whenever the clinic remains open, please call to cancel your appointment if weather conditions prevent your attendance.



CONTACTING US

Our office hours are 8:30 a.m. to 8:00 p.m., Monday through Friday and 8:00 a.m. to 4:00 p.m. on Saturday. We make every attempt to answer every call; however, you may at times have to leave a message. Messages are checked often and calls returned promptly. Late afternoon or evening messages left may be answered the morning of the next business day. Please do not ever leave an urgent message on voicemail. It is best to contact your therapy provider directly for urgent messages, cancellations and scheduling questions.

ABOUT COUNSELING THERAPY

Individuals consult with Mental Health Professionals (MHPs) for a variety of reasons. We will make every effort to respect your individual needs and goals in treatment. The therapy process involves a working partnership between you and your MHP. Our work may include a variety of activities, and for optimum outcomes to occur, your active participation is essential. We will attempt to help you achieve your goals, but we cannot guarantee that the outcome will be what you now seek. In addition, change is often accompanied by feeling states that can be distressing. You may experience moments of frustration, anxiety, feelings of depression, self-doubt, and confusion. While we are trained, licensed and experience MHPs, we cannot guarantee change nor can we promise that all problems will be resolved.

For counseling therapy with children under the age of 14, it is our policy to request an agreement in which parents (or guardians) consent to give up access to the child's records. If a diagnostic evaluation or assessment is requested, we will discuss findings, results, and treatment plans with you. Most of the minors we see are brought voluntarily by their parents and come with parental knowledge. In such circumstances, parents are often understandably curious about the treatment of their children. It is our position, however, that young people need to develop trust in their therapist and need some degree of security and privacy. Therefore, we specifically request that you limit your inquiry about the details of their therapy. We need you to know that we will, indeed, bring to your attention matters that we believe are important for you to know, and we request that you trust our judgment about this important issue. We also hope that you will refrain from asking your child what has transpired in therapy or diagnostic sessions.

If your child is 14 or over, we cannot discuss anything about evaluation or treatment with you without the written Authorization from your child.

CONFIDENTIALITY

The law protects the privacy of all communications between a Client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health, therapy, and mental health professionals about a case. During a consultation, we avoid revealing the identity of our Client. Nonetheless, the other professionals are still legally bound to keep the information confidential. Unless you object, we may not tell you about these consultations, unless we feel that it is important to our work together.
- You should be aware that we practice with other therapists and mental health professionals, and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and



quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.

• If a Client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or authorization.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-Client privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a Client files a complaint or lawsuit against one of us, we may disclose relevant information regarding that Client in order to defend ourselves.
- If a Client files a worker's compensation claim, we may disclose information relevant to that claim to the Client's employer or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a Client's treatment. These situations are unusual in our practice.

- If we know or suspect that a Client under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Illinois Department of Client and Family Services (DCFS). Once such a report is filed, we may be required to provide additional information.
- If we know or suspect that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually DCFS. Once such a report is filed, we may be required to provide additional information.
- If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), we may disclose that information, but only to those reasonably able to prevent or lessen the threat.

If one of these situations arises, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.



PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, test results, and any reports that have been sent to anyone, including reports to your insurance carrier. If you provide us with an appropriate written request, you have the right to examine and/or receive a copy of your records, expect in unusual circumstances that involve danger to you or others. In those situations, you have the right to have your record sent to another provider. In most situations, we are allowed to charge a copying fee of \$25. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we may also keep a set of Therapy Notes. These notes are for our own use, and are designed to assist us in providing you with the best treatment. While the contents of therapy notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. These Therapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Therapy Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Therapy Notes unless we determine that such disclosure would be reasonably likely to be detrimental to your health. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We will be happy to discuss any of these rights with you.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ALL TERMS.

Printed Name of Client/Guardian

Client/Guardian Signature

Date Signed





Inscreeness MADDICAD TRECANE OPA PAIL Image: Control of the contr	Indicative RECICUL: TRCARE CHAMPYA REAL REAL Control Is. AND/EDD 10. NUMBER (Por Program to Name) PATIENTS NAME (Last Name, First Name, Mode Indian) 3. PATIENT BRITN UST: 0.2. F F F F F F 4. MEDICAD The Address Name) F 4. MEDICAD F 4. MEDICAD F <th>IBICA</th> <th>ORM CLAIM COMMITTEE (NUCC</th> <th>02/12</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>PICA</th>	IBICA	ORM CLAIM COMMITTEE (NUCC	02/12										PICA
JANGELOW	Albellower Albello	PICA MEDICAID	TRICARE	101401/0	GR	OUR	FECA	OTHER	ta INSURED'S LD M	UMBER			(Eor Proora	
MM DD V	MM Do Y Image: Control of the control					ALTH PLAN	BLK LUN	G	14. 14001120 0 1.0.1	Children			(i or i rogia	in in noin 1)
ATLENT & ADDRESS (No., Silved)	Image: Contract of the second secon	PATIENT'S NAME (Last Name,	First Name, Middle Initial)		3. PATIENT	T'S BIRTH DAT	Ē	SEX	4. INSURED'S NAME	(Last Nam	ne, First	Name, Mi	ddle Initial)	
Self Secure Date Onde Onde Y TATE RESERVED FOR NUCC USE CITY TATE * CODE TELEPHONE (Induk Ans. Cost) ZIP CODE TELEPHONE (Induk Ans. Cost) OTHER NEURED'S POLICY OR GROUP REMIET 10. IS PATIENT'S CONDITION RELATED TO. TI. HEURED'S POLICY OR GROUP REMIET OTHER NEURED'S POLICY OR GROUP REMIET E. BAPLOYABUTY (Current in Prevent) a. EMPLOYABUTY (Current in Prevent) A. EMPLOYABUTY (Current in Prevent) a. EMPLOYABUTY (Current in Prevent) a. EMPLOYABUTY (Current in Prevent) BESERVED FOR NUCC USE C. OTHER ACCOBETY PLACE (Iso) D. OTHER ACCOBETY RESERVED FOR NUCC USE C. OTHER ACCOBETY PLACE (Iso) D. OTHER ACCOBETY RESERVED FOR NUCC USE C. OTHER ACCOBETY PLACE (Iso) D. OTHER ACCOBETY NULBANCE PLAN NAME OR PROGRAM NAME TID. CLAMA CODES (Integrational transmitter) E. REUNANCE PLAN NAME OR PROGRAM NAME RESERVED TO RATIONAL COMMENTER COMPLETENDER SIGNATURE COMPL	Bell Goods Othell One ITTY ITY ITATE B. RESERVED FOR NUSC USE CITY ITATE IP CODE TELEPHONE (Include Area Code) II. ISSURED'S NAME (Last Name, First Name, Models Infact) III. ISSURED'S POLICY OF GROUP MURDER IIII. ISSURED'S POLICY OF GROUP MURDER IIIII. ISSURED'S POLICY OF GROUP MURDER IIIII. ISSURED'S POLICY OF GROUP MURDER IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII						м							
IN EACH PROVIDE (Include A real Cubit) CITY ETATE * CODE TELEPHONE (Include A real Cubit) CITY CITY<	TY B A REGRIVED FOR NUCC USE CITY STATE B A REGRIVED FOR NUCC USE CITY STATE P GODE TELEPHONE (Include Aves Code) () STATE B A REGRIVED FOR NUCC USE CITY STATE P GODE TELEPHONE (Include Aves Code) () STATE CITY STATE P GODE TELEPHONE (Include Aves Code) () STATE CITY STATE OTHER INSURED'S POLICY OR GROUP NUMBER A EMPLOYMENT? Current or Previous) II. INSURED'S POLICY OR GROUP NUMBER BEX EMPLOYMENT? Current or Previous) II. INSURED'S POLICY OR GROUP NUMBER BEX III. INSURED'S POLICY OR GROUP NUMBER BEX III. INSURED'S POLICY OR GROUP NUMBER BEX III. INSURED'S POLICY OR GROUP NUMBER IIII. INSURED'S POLICY OR GROUP NUMBER IIII. INSURED'S POLICY OR GROUP NUMBER IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	PATIENT'S ADDRESS (No., St	reet)						7. INSURED'S ADDR	ESS (No.,	Street)			
CODE TELEPHONE (Induide Area Color) TE	CODE TELEPHONE (Include Area Code) TELEPHONE (Include Area Co	TV		TATE	0.000			Other	CITY					STATE
OTHER INSURED'S MARE Last Name, Made Instabil 10. IS PATIENTS CONDITION RELATED TO. 11. INSURED'S POLICY OROUP OF FECA NUMBER a. EMPLOYABILITY (Current or Previous) a. EMPLOYABILITY (Current or Previous) a. INSURED'S DATE OF BITTY BC messenved Dron NuCC USE b. AUTO ACCIDENT? PLACE (Bath) b. OTHER ACCIDENT? C. INSURACE OF BITTY BC messenved Dron NuCC USE c. OTHER ACCIDENT? PLACE (Bath) b. OTHER ACCIDENT? c. INSURACE OF PROGRAM NAME III. INSURED'S DATE OF BITTY BC PATEMANCE FLAN NAME OF PROGRAM NAME III. CLAMM CODE (Designatud by NLCC) III. INSURED'S DATE OF DIRITY III. INSURED'S DATE OF BITTY III. INSURED'S DATE OF BITTY PATEMANCE FLAN NAME OF PROGRAM NAME IIII. CLAMM CODE (Designatud by NLCC) III. INSURED'S DATE OF DIRITY III. INSURED'S DATE OF BITTY INSURED'S INSURATIVELE LUMINOSE	Children Beck (Last Name, Piets Name, Middle Indiad) 10. IB PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY OR GROUP OR FICA NUMBER Children INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previola) a. INSURED'S DATE OF BITTY M F RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Bate) b. OTHER ACIDE OF BITY M F RESERVED FOR NUCC USE c. OTHER ACIDENT? E. INSURED'S DATE OF BITY M F RESERVED FOR NUCC USE c. OTHER ACIDENT? E. INSURANCE PLAN NAME OR PROGRAM NAME E. INSURANCE PLAN NAME OR PROGRAM NAME INSURANCE PLAN NAME OR PROGRAM NAME I.O. CLAIM CODES (Disignated by NUCC) E. INSURANCE PLAN NAME OR PROGRAM NAME PRESERVED FOR NUCC USE e. OTHER ACIDENTIF E. INSURANCE PLAN NAME OR PROGRAM NAME PRESERVED COL CLAIM NETOPIE COMPLETING STRUCTURE I submote the metable of other thomation necessary Instructure in any provide in a			INTE	6. HEGEN	LDTON NOC	0.005		GITT					SIAIL
OTHER INSURED'S POLICY OR GROUP NUMBER		P CODE	TELEPHONE (Include Area Cod)					ZIP CODE		TEL	EPHONE (Include Are	a Code)
OTHER INSURED'S POLICY OR GROUP NUMBER			()									())	
MML DO VML F RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Bas) b. OTHER ACCIDENT? c. OTHER ACCIDENT	MM DD YY M F RESERVED FOR NUCC USE b. AUTO ACCIDENT? pt ACE (State) b. OTHER CAUM ID (Designated by NUCC) Intelserved For NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME Insurance Plan NAME OR PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAN? Insurance Plan NAME OR PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAN? PATEINT'S OR AUTOPOLICE PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAN? PATEINT'S OR AUTOPOLICE PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAN? PATEINT'S OR AUTOPOLICE PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) 10. INSURANCE PLAN NAME OR PROGRAM INAME PATEINT'S OR AUTOPOLICE PROGRAM INAME 10. CLAIM INFORMATION (Designated by NUCC) 10. INSURANCE PLAN NAME OR PROGRAM INAME SIGNED DUAL ONTE SIGNED SIGNED SIGNED DUAL ONTE DO YY NAME OF REFERENTING PROGRAM INC UNDERNT OWNER OF THE FORM DO YY NAME OF REFERENTING PROGRAM INC UNDERNT OWNER OW	OTHER INSURED'S NAME (La	ist Name, First Name, Middle Initi)	10. IS PAT	ENT'S CONDI	TION RELA	TED TO:	11. INSURED'S POLI	CY GROU	PORF	ECA NUM	BER	
Mill DD VY M F RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Blast) b. OTHER ACCIDENT? b. OTHER ACCIDENT? c. OT	MM DD YY M_ F RESERVED FOR NUCC USE b. AUTO ACCIDENT? prace (status) b. OTHER CLAIM ID (Designated by NUCC) INSURANCE PLAN NAME OR PROGRAM NAME c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME INSURANCE PLAN NAME OR PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH EXAMPLE OR PROGRAM NAME PATEINTS OR AUTOCIDED FOR SIGNATURE LIABURGE BY READED STORM THE FORM. 1.3. INSURANCE PLAN NAME OR PROGRAM NAME PATEINTS OR AUTOCIDED FOR SIGNATURE LIABURGE BY READED STORM THE FORM. 1.3. INSURED STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME PATEINTS OR AUTOCIDED FOR SIGNATURE LIABURGE BY READED STORM THE FORM. 1.3. INSURED STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME PATEINTS OR AUTOCIDED FOR SIGNATURE LIABURGE BY READED STORM THE FORM. 1.3. INSURED STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME PATEINTS OR AUTOCIDED FOR SIGNATURE LIABURGE BY READED STORM THE FORM. 1.3. INSURED STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME STORED DUAL OTHER STORM THE FORM. 1.3. INSURE STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME STORED DUAL OTHER STORM THE FORM. 1.3. INSURE STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME STORED DUAL OTHER STORM THE FORM. 1.3. INSURE STORM THE AUTOMIC PLAN NAME OR PROGRAM NAME STORED OUTAL OTHER STORM THE FORM. 1.3. INSURE STORM THE STORM THE STORM THE STORM THE STORM THE STORM THE ST				ELIDI OL	(1.10°)							0.514	
HESERVED FOR NLICC USE b. AUTO ACCIDENT? PLACE (Bans) HESERVED FOR NLICC USE c. OTHER ACDIDENT? No HESERVED FOR NLICC USE c. OTHER ACDIDENT? No L. AUTO ACCIDENT? c. OTHER ACDIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME INSURANCE PLAN NAME OR PROGRAM NAME 102. CLAIM CODES (Desprated by NUCC) d. IS THERE ANDTHER HEALTH BENEFIT PLAN? INSURANCE PLAN NAME OR PROGRAM NAME 102. CLAIM CODES (Desprated by NUCC) d. IS THERE ANDTHER HEALTH BENEFIT PLAN? INSURANCE PLAN NAME OR PROGRAM NAME 102. CLAIM CODES (Desprated by NUCC) d. IS THERE ANDTHER HEALTH BENEFIT PLAN? INSURANCE PLAN NAME OR PROGRAMS SIGNATURE I Laubricise the release of ary medial or othe public in the undersigned physician or supplier to process the class described block. 10. INTER DATE INSURANCE OF PRECENTRY, ILLNESS, INJURY, OF PRECINANCY (MP) IS. OTHER DATE MM OD CURRENT, ILLNESS, INJURY, OF PRECINANCY (MP) IS. OTHER DATE MM DD YY INAL OF REFERENT PLANS IS. OTHER DATE MM DD YY IS ONED ONTEGO FOR TATURY, OPRECINANCY (MP) IS. OTHER DATE MM DD YY IS ONED ADD THER DATE QUAL DD QUAL DD QUAL	HESERVED FOR NUCC USE b. AUTO ACCORPTY PLACE (Stat) b. OTHER CLAIM ID (Designated by NUCC) INSURANCE PLAN NAME OF PROGRAM NAME c. OTHER ACCORPT c. INSURANCE PLAN NAME OF PROGRAM NAME INSURANCE PLAN NAME OF PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAP? INSURANCE PLAN NAME OF PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAP? INSURANCE PLAN NAME OF PROGRAM NAME 10. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT FLAP? PATEENTS OR AUTHORIZED PERSON'S BIGNATURE I automation the design of the party who accepts assignment before on whole accepts assignment before on the party who accepts assignment before described bolow. 11. BUSINEED'S OF AUTHORIZED FERSON'S BIGNATURE I automation or aspect before on whole accepts assignment of government benefits enter to myself of to the party who accepts assignment before on whole accepts assignment of DOAL 13. DOATES PATIENT, UNABLE TO WORK IN CURRENT OCCUPATION TO OLAL. NAME OF REFERENCES, INJURY, or PREGNANCY (LMP) 10. OTHER TALIN MM DD YY FROM TO NAME OF REFERENCES OR INJURY Paties AL to service the below (24E) ICD Ind. 20. PICCE INTS ACCOUNT NO. 20. PICCE INTS ACCOUNT NO. 20. PICCE INTS ACCOUNT NO. NDD VY MM DD VY SERVICES, OR SERVICES, OR SUPPLIES DOATES FATTER NUMEER NPI	UTHEN INSURED'S POLICY C	IN GROUP NUMBER		a. EMPLO	-			MM DD	YY		мГ	J	-
PESERVED FOR NUCC USE	PESERVED FOR NUCC USE OTHER ACCIDENT? OTHER ACCIDENT? OTHER ACCIDENT? OTHER ACCIDENT? ADD ACK OF FORM BEFORE COMPLETING & BIGNING THE FORM. Iso request payment of government benefits of the understand by NUCC) Iso request payment of government benefits of the understand trig FORM. More of the request payment of government benefits entry of the paymy via accepts assignment SIGNED JATE OF QUARENT, LLINESS, INJURY, or PREGNANCY (JMT) Is OTHER DATE JATE OF QUARENT, LLINESS, INJURY, or PREGNANCY (JMT) Is OTHER DATE JAL JAL	RESERVED FOR NUCC USE			b. AUTO A				b. OTHER CLAIM ID	(Designate	d by N			
Image: Note of the process of the second	INSURANCE PLAN NAME OR PROGRAM NAME									, grinte				
NSUPANCE PLAN NAME L<	INSURANCE PLAN NAME OR PROGRAM NAME I.I.C.LAIM CODES (Designated by NUCC) I.I.S.THERE ANOTHER HEALTH BENEFIT PLAN? Image: Contract of the indexistory o	RESERVED FOR NUCC USE			c. OTHER	ACCIDENT?			c. INSURANCE PLAN	NAME OF	R PRO	BRAM NAM	ME	
NEED BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. Image: Complete lands and significant conservations accessing significant conservation accessing significant benefits either to expect of any medical or other information accessing significant benefits in the undersigned physician or supplier for benefits either to expect of any medical or other information accessing significant benefits in the undersigned physician or supplier for benefits either to expect of any medical or other information accessing significant benefits either to expect of any medical or other information accessing significant benefits and the undersigned physician or supplier for benefits either to expect of any medical benefits or the undersigned physician or supplier for benefits benefits and the undersigned physician or supplier for benefits and the undersigned physician or supplier for benefits and the undersigned physician or supplier for benefits benefits and the undersigned physician or supplier for benefits and the undersite the benefits and the undersigned physicits and the under	Tech Dack OF PORM BECOMPLETING & SIGNATURE FLATHED FORM. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE FLATHED COMPLETION OF INTERCE OF Other information necessary between described below. SIGNED DATE OF COMPLETING PROVIDER ON OTHER FORM. DATE OF COMPLETING PROVIDER ON OTHER SOURCE DATE OF COMPLETING PROVIDER ON OTHER SOURCE TABLE OF COMPLETING PROVIDER ON THE SOURCE <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>													
Index Dark OF FORE DEFORE COMPLETING & BIONNO THIS FORM. PATIENT SCI AUTHORIZED PERSON'S SIGNATURE Lambrase therefile either to myself or to the party who accepts assignment. 10. MSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lambrase therefile either to myself or to the party who accepts assignment. SIGNED DATE SIGNED OUNCL OUNCL </td <td>READ BACK OF FORM BEFORE COMPLETING & BIONNO THE FORM. PATIENTS OF ALTHORIZED FEISON'S BIONATURE Lathorize the release of any medical or other information neoessary to process this claim. Lake request payment of government benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts as</td> <td>NSURANCE PLAN NAME OR</td> <td>PROGRAM NAME</td> <td></td> <td>10d. CLAIN</td> <td>CODES (Des</td> <td>ignated by</td> <td>NUCC)</td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>	READ BACK OF FORM BEFORE COMPLETING & BIONNO THE FORM. PATIENTS OF ALTHORIZED FEISON'S BIONATURE Lathorize the release of any medical or other information neoessary to process this claim. Lake request payment of government benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts assignment benefits either to myself or to the party who accepts as	NSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIN	CODES (Des	ignated by	NUCC)		-				
PATIENTS OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information resonances payment of medical banefits to the undersigned physician or supplier to process that decrete adjusted assignment to mysice if to the putry who accels assignment to mysice if to the putry who accels assignment to mysice if to the putry who accels assignment to mysice if to the putry who accels assignment to mysice if to the putry who accels assignment to mysice if to the putry who accels assignment to mysice if to the putry who accels assignment to mysice if to mysice if to the putry who accels assignment to mysice if to mysice if to mysice if to the putry who accels assignment to mysice if the putry who accels assignment to mysice if the putry who accels assignment to mysice if to mysice if the putry who accels assignment to mysice if the putr	PATIENTS OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this define the underrighted by who accepts assignment. Takes described below. payment of medical benefits to the underrighted physician or supplied of the party who accepts assignment. Biometry in the process the described below. DATE SIGNED SIGNED DATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY NAME OF REFERENTS OR AUTHORING PROVIDER OR OTHER SOURCE 17. MPI International control of the source internation of the party who accepts assignment. 16. DATES partent y UNABLE TO WORK IN CURRENT OCCUPATION OF TO CURRENT SERVICES. NAME OF REFERENTS OR NUMPY Relate A-L to service line below (24E) ICD Ind. International control of the party who accepts assignment. 10. HOSPITALIZATION NUMBER 22. PRIOR AUTHORIZATION NUMBER DIAGNOSIS OF NATURE OF ILLINESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. PRIOR AUTHORIZATION NUMBER 22. PRIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE B. C. D. D. DATE DATE DATE MOD YY MM DO YY SCHARGES UNITSICON NPI 22. PRIOR AUTHORIZATION NUMBER PROVEREND MOD YY MM DO YP DATE </td <td>BEAD</td> <td>BACK OF FORM BEFORE COM</td> <td>LETING</td> <td>& SIGNING</td> <td>THIS FORM</td> <td></td> <td></td> <td></td> <td>_</td> <td></td> <td></td> <td></td> <td></td>	BEAD	BACK OF FORM BEFORE COM	LETING	& SIGNING	THIS FORM				_				
below: SIGNED DATE DATE SIGNED DATE SIGNED DATE SIGNED SI	below. DATE SIGNED SIGNED BIGNED OLAL OLAL III. DATES MATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MARE OF REFERRING PROVIDER OR OTHER SOURCE 172 174 MM DD YY ANME OF REFERRING PROVIDER OR OTHER SOURCE 172 174 MM DD YY ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 18 HOSHITALZATION DATES, RELATED TO CURRENT SERVICES, MM 18 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relation of the source in below (24E) ICD Ind. 18 22 REGUBINISSION DIAGNOSIS OR NATURE OF ELLNESS OR INJURY Relation of the source in below (24E) ICD Ind. 22 REGUBINISSION ORIGINAL REF. NO. A DATE(S) OF SERVICE B. C. D. D. 23 PRIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE FACLE OF EMAGE B. C. D. D. 20 PRIOR AUTHORIZATION NUMBER A DD Y MM DD Y PROCEDURES. SERVICES, OR SUPPLIES DEANOSIS F. DIAGNOSIS MARCES MODEFIND A DATE(S) OF SERVICE B. C. D. PROCEDURES. SERVICES, OR SUPPLIES DEANOSIS F. DIAGNOSIS MARCES MODEFIND A DD Y MM DD YY SERVICE EMAG C	PATIENT'S OR AUTHORIZED	PERSON'S SIGNATURE I auth	rize the n	elease of an	y medical or oth	er informati	on necessary	payment of medic	al benefits	to the u	ndersigne	d physician	or supplier fo
DATE OD CURRENT (LLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE QUAL MM DD YY 16. DATES PATIENT (JANALE CP) WORK IN CURRENT OCCUPATION FROM MM DD YY NAME OF REFERENCE PROVIDER OR OTHER SOURCE 17a, 17b, NPI 17a, NPI 17a, 17b, NPI 18. MOSTINUE OF PROVIDER SERVICES FROM 18. MOSTINUE SERVICES FROM 18. MOSTINUE SERVICES FROM 18. MOSTINUE SERVICES FROM 20. OUTSIDE LAB? 3 CHARGES JULACIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 3 CHARGES 22. RESUMMSSION DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) JULACION D. 22. RESUMMSSION ORIGINAL REF. NO. A DATE(S) OF SERVICE M DD V MM DD VY SERVICE SOR SUPPLIES DIAGNOSIS DIAGNOSIS F. DIAGNOSIS M DD VY MM DD VY SERVICE DIAGNOSIS F. DIAGNOSIS PROVENTION NUMBER FEDERAL TAX LD. NUMBER SINPL SERVICE DIAGNOSIS S. PROVIDER ID. # NPI FEDERAL TAX LD. NUMBER SINPL 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ALSS GRAMENT' YES S. S. S. NPI SEGMATURE OF PHYSICIAN OR SUPPLICE INCOUDING DEGREES OR O	DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 16. OTHER DATE QUAL MM DD YY T6. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATIO FROM TO NAME OF REPERRING PROVIDER OR OTHER SOURCE 178, 178, 178, 178, 178, 178, 178, 178,	below.												
OUAL FROM TO NAME OF REPERTING PROVIDER OR OTHER SOURCE 17a 17b 17	OUAL. UAR PROM TO NAME OF REFERENING PROVIDER OR OTHER SOURCE 17a 17b NPI 18 HOSPITALIZATION DATE SPELATED TO CURRENT SERVICES MM DD CV ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. RESUBNISSION ORIGINAL REF. NO. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) D. 23. PRIOR AUTHORIZATION NUMBER C K C D. D. 23. PRIOR AUTHORIZATION NUMBER C M D. K L K L K M DO YY MM DD YY SERVICE ROP C Response Number Not Number PROVIDER ID M DO YY MM DD YY SERVICE ROP C MODIFIES PROVIDER ID PROVIDER ID M DO YY SERVICE ROP MODIFIES PROVIDER ID NPI NPI M DO YY SERVICE ROP NPI				D	ATE			SIGNED					
UDUL. UDUL. IPROFILE IPROFILE <thiprofile< th=""> <thiprofile< th=""> <thipro< td=""><td>UDAL. DUAL. <th< td=""><td>MM DD YY</td><td>S, INJURY, or PREGNANCY (LM</td><td>) 15.0</td><td></td><td>EMM</td><td>DD</td><td>YY</td><td></td><td>UNABLE</td><td>ro wo</td><td>RK IN CUP</td><td>ARENT OC</td><td>CUPATION</td></th<></td></thipro<></thiprofile<></thiprofile<>	UDAL. DUAL. DUAL. <th< td=""><td>MM DD YY</td><td>S, INJURY, or PREGNANCY (LM</td><td>) 15.0</td><td></td><td>EMM</td><td>DD</td><td>YY</td><td></td><td>UNABLE</td><td>ro wo</td><td>RK IN CUP</td><td>ARENT OC</td><td>CUPATION</td></th<>	MM DD YY	S, INJURY, or PREGNANCY (LM) 15.0		EMM	DD	YY		UNABLE	ro wo	RK IN CUP	ARENT OC	CUPATION
Interview 17b. NPI FROM TO ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Polate A-L to service line below (24E) ICD Ind. 22. BESUMENSSION ORIGINAL REF. NO. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Polate A-L to service line below (24E) D. 22. BESUMENSSION ORIGINAL REF. NO. L F. G. L D. 23. PRIOR AUTHORIZATION NUMBER ADATE(S) OF SERVICE B. C. D. PROVIDERS, SERVICES, OR SUPPLIES DIAGNOSIS Y M DD YY SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS S CHARGES PROVIDERING, PROVIDERING, PROVIDERING, POINTER S CHARGES PROVIDERING, PROVIDERING, PROVIDERING, POINTER S CHARGES PROVIDERING, PROVIDERIN	Image: International claim information (beginnated by NUCC) To To ADDITIONAL CLAIM INFORMATION (beginnated by NUCC) 20. OUTSIDE LAB? \$ CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. DUTSIDE LAB? \$ CHARGES DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. RESUBMNSSION ORIGINAL REF. NO. L B. C. D. B. C. D. 23. PRIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES DIAGNOSIS \$ CHARGES H. H. M DD YY MM DD YY SERVICE EMB CPT/HCPCS MODIFIER DIAGNOSIS \$ CHARGES PROVIDER ID Y M DD YY SERVICE EMB CPT/HCPCS MODIFIER DIAGNOSIS NPI NPI Y M DD YY SERVICE EMB NPI NPI NPI NPI Y SCHARGES NPI NPI NPI NPI NPI NPI Y M DD YY SERVICE									N DATES	RELAT		JRRENT SE	RVICES
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 20. OUTSIDE LAB	ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES IDIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. RESUBMISSION ORIGINAL REF. NO. IDIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) D 23. PRIOR AUTHORIZATION NUMBER ORIGINAL REF. NO. IDIAGNOSIS OF SERVICE B. C. D. 23. PRIOR AUTHORIZATION NUMBER ORIGINAL REF. NO. IA DATE(5) OF SERVICE B. C. D. PROVEDURES, SERVICES, OR SUPPLIES E. F. O/Y BERVICE EMB SIGN PROVIDER INFORMATION NUMBER IA DATE(5) OF SERVICE EMB SIGN D. PROVEDERING PROVIDER INFORMATION NUMBER PROVIDER INFORMATION NUMBER PROVIDER INFORMATION NUMBER IA DATE(5) OF SERVICE EMB SIGN O/Y SERVICE EMB SIGN D/Y SERVICE EMB SIGN PROVIDER INFORMATION NUMBER NPI IA DATE(5) OF SERVICE EMB SIGN INPI INPI INPI INPI IA DATE(5) OF SERVICE EMB SIGN INPI INPI INPI INPI IA DATE(5) OF SERVICE EMB SIGN INPI INPI INPI INPI IA IA <			100 million (100 million)						Y	Y	то	MM DE	YY
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. B. C. C. B. C. C. D. C.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 22. REQUEMISSION ORIGINAL REF. NO. B. C. D. 23. PRIOR AUTHORIZATION NUMBER 23. PRIOR AUTHORIZATION NUMBER Image: Antiper Stress of the service line below (24E) D. 23. PRIOR AUTHORIZATION NUMBER Image: Antiper Stress of the service line below (24E) D. 23. PRIOR AUTHORIZATION NUMBER Image: Antiper Stress of the service line below (24E) D. E. F. Image: Antiper Stress of the service line below (24E) D. E. F. D. Image: Antiper Stress of the service line below (24E) D. H. E. F. D. Image: Antiper Stress of the service line below (24E) H. L E. F. D. D. Image: Antiper Stress of the service line below (24E) H. L E. F. D. D. PROVIDERING Image: Antiper Stress of the service line below (24E) Image: Antiper Stress of the service line below (24E) Image: Antiper Stress of the service line below (24E) Image: Antiper Stress of the service line below (24E) Image: Antiper Stress of the service line below (24E) Image: Antiper Stress of the service line below (24E) Image: Antipe	ADDITIONAL CLAIM INFORM	ATION (Designated by NUCC)						20. OUTSIDE LAB?			\$ CHA	RGES	
B. C. D. CODE CHIGINAL REF. NO. CODE CODE CODE CODE CODE CODE I F. G. H. Image: Control of Support 23. PRIOR AUTHORIZATION NUMBER A DATE(S) OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. D. PROVIDER ID.	Image: Source of the second									NO				
F. G. H. 23. PRIOR AUTHORIZATION NUMBER A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. D. YM DD YY MM DD YY Schartige PEOD YM DD YY Schartige Schartige E. F. D. PROCEDURES, SERVICES, OR SUPPLIES PEOD YY MM DD YY Schartige PEOD RENDERING PROVIDER ID Schartige PEOD PROVIDER ID PEOD PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID PROVIDER ID <t< td=""><td>F. G. H. E. B. C. H. E. D. PROCEDURES.SERVICES.OR SUPPLIES E. E. D. D. PROCEDURES.SERVICES.OR SUPPLIES E. E. D. D. PROCEDURES.SERVICES.OR SUPPLIES E. E. F. D. PROCEDURE D. PROVIDER ID PROVIDER I</td><td>DIAGNOSIS OR NATURE OF</td><td>ILLNESS OR INJURY Relate A</td><td>to servic</td><td>ce line below</td><td>v (24E) ICI</td><td>D Ind.</td><td></td><td>22. RESUBMISSION CODE</td><td>1</td><td>ORIC</td><td>INAL REF</td><td>NO.</td><td></td></t<>	F. G. H. E. B. C. H. E. D. PROCEDURES.SERVICES.OR SUPPLIES E. E. D. D. PROCEDURES.SERVICES.OR SUPPLIES E. E. D. D. PROCEDURES.SERVICES.OR SUPPLIES E. E. F. D. PROCEDURE D. PROVIDER ID PROVIDER I	DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY Relate A	to servic	ce line below	v (24E) ICI	D Ind.		22. RESUBMISSION CODE	1	ORIC	INAL REF	NO.	
F. G. H. H. A. DATE(6) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From DD YY MM DD YY SERVICE EMG OP YY MM DD YY SERVICE EMG DIAGNOSIS POINTER S CHARGES DIAGNOSIS C. PROVIDER ID. # M DD YY MM DD YY SERVICE EMG CPTHCPCS MODIFIER POINTER S CHARGES DIAGNOSIS C. RENDERING POINTER SCHARGES UNTR MODIFIER POINTER S CHARGES DIAGNOSIS DIAGNOSI	F. G. H. H. <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>23. PRIOR AUTHOR</td><td>ZATION N</td><td>UMBER</td><td>3</td><td></td><td></td></td<>								23. PRIOR AUTHOR	ZATION N	UMBER	3		
A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES From YY MM DD YY SERVE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT HCPCS E. DIARNOSIS POINTER F. G. M. H. L. J. BACCO SCHARGES H. L. J. BENDERING OPT HCPCS A. RENDERING POINTER M DO YY MM DD YY MM DD YY SERVE EMG OPT HCPCS MODIFIER DIARNOSIS POINTER S CHARGES MOTIFIER NPI I DO YY MM DD YY SERVE EMG OPT HCPCS MODIFIER DIARNOSIS POINTER NPI NPI I DO YY MM DD YY SERVE EMG PROVIDER ID.# NPI NPI I DO YY I DO YY SERVE I DO YY S CHARGES NPI NPI I DO YY I DO YY S CHARGES I DO YY NPI NPI NPI I DO YY I DO YY S CHARGES I DO YY I DO YY NPI NPI I DO YY S CHARGES S CHARGES I DO YY NPI NPI I DO YY S CHARGES S PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Drog OV. Cambre See Decoto? S OV. Cambre See Decoto? S SUCATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVID	A. DATE(5) OF SERVICE B. C. D. PROCEDURES, SERVICES OR SUPPLIES E. DIAGNOSIS F. D. MACCOF H. H. D. MACCOF H. H. D. MACCOF H. H. D. MACCOF PROVENUE PROVENUE DIAGNOSIS S CHARGES M. D. MACCOF PROVENUE PROVENUE PROVENUE PROVENUE PROVENUE PROVENUE N. M. D. M. M. D. M. M. D. M. M. D. M. M. M. D. M.		F											
M DD YY MM DD YY GENUE EMG CPT/HCPCS MODIFIER POINTER \$ CHARGES UNT PROVIDER ID. # PROVIDER ID. # POINTER \$ CHARGES UNT PAID NPI NPI FEDERAL TAX LD. NUMBER SSN EIN FEDERAL TAX LD. NUMBER SSN EIN SCIUDING DEGREES OR CREDENTIALS (certify that the statements on the reverse) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	M DD YY MM DD YY SERVCE EMG OPTIMOPCS MONINAL MODIFIER POINTER \$ CHARGES UNT PROVIDER ID PROVIDER ID PROVIDER ID NPI			PROCED	DURES, SE	RVICES, OR S	Real Providence		F.	G.	H.	- l.	-	J.
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Description of the strength of the strengt of the strength of the strength of the strengt of the			(Explai PT/HCPC	In Unusual C	MODIFIE	R	POINTER	\$ CHARGES	OR	Family Plan	ID. QUAL.	PRO	VIDER ID. #
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Provide the manual state of the state of th	The stand of the second			1			-	L	1				
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Frog on: clamb dee backet? 28. TOTAL CHARGE 29. AMOUNT PAID SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (ICORTIVITIE the statements on the reverse) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	FEDERAL TAX I.D. NUMBER 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 29. TOTAL CHARGE 29. AMOUNT PAID SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # 4					and and and and			1	-	1	NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Frog on: clamb dee backet? 28. TOTAL CHARGE 29. AMOUNT PAID SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (ICORTIVITIE the statements on the reverse) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	FEDERAL TAX I.D. NUMBER 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 29. TOTAL CHARGE 29. AMOUNT PAID SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # 4				1			1	L E	1	1	NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Degiste destroy 28. TOTAL CHARGE 29. AMOUNT PAID Signature of Physician or supplier 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # 4	-ttti				and the stars		1997		-				CONTRACTOR OF
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (or gont, claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NI SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()											NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? FO'OV, Clamp, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? Y OP SON: Gimm see backing Y OP SON: Gimm see backing S SIGNATURE OF PHYSICIAN OR SUPPLIER 30. Rsvd for NI SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()				100					100			Liller 1	New York
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? FOR GOIN COMPANY 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (iccritity that the statements on the reverse) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	FEDERAL TAX I.D. NUMBER SIN EIN 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 29. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NI SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()						_				-	NPI		
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? FOR SUPER COMPARISON OF A DEVICE ACCOUNT PAID 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (ICentify that the statements on the reverse) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	FEDERAL TAX I.D. NUMBER SSN EIN 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 29. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NI SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	TTTT			1				1	1	1	NPI		
FEDERAL TAX LD. NUMBER SSN. EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for Ni YES YES NO \$ \$ \$ SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()				d		-	-			-			
Image: Including dee backing Image:	Iter opput, claims, see back/ YES YES NO \$ \$ SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()											and the second se		
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (iccritight the statements on the reverse	SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	FEDERAL TAX I.D. NUMBER	SSN EIN 26. PAT	ENT'S A	CCOUNT N	O. 27. A				1		JNT PAID	30. F	svd for NUC
INCLUDING DEGREES OR CREDENTIALS	SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	The second second					100000	NO	1.27					
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	INCLUDING DEGREES OF CREDENTIALS	INCLUDING DEGREES OR C	REDENTIALS	ICE FAC	CILITY LOC	ATION INFOR	MATION		33. BILLING PROVIE	ER INFO 8	4 PH #	()	
	(I certify that the statements on the reverse apply to this bill and are mathematical apart thereof.)	(I certify that the statements o apply to this bill and are made	n the reverse a part thereof.)											

