CEDAR HEALTH PLAN
PO BOX 24170
AUSTIN, TX 78755

REF: CSM-240415-04217

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) [X] | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): CHP0842719

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MORGAN, AVERY

3. PATIENT'S BIRTH DATE (MM DD YY): 08 19 1987 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MORGAN, AVERY

5. PATIENT'S ADDRESS (No., Street): 4407 WILLOW BEND LN APT 204

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 4407 WILLOW BEND LN APT 204

CITY: AUSTIN | STATE: TX

8. RESERVED FOR NUCC USE

CITY: AUSTIN | STATE: TX

ZIP CODE: 78731 | TELEPHONE (Include Area Code): (512) 555 0146

ZIP CODE: 78731 | TELEPHONE (Include Area Code): (512) 555 0146

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: GRP-04217

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): 08 19 1987 | SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: CEDAR CHOICE PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] 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.

SIGNATURE ON FILE | DATE: 04/15/2024

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 04 15 26 | QUAL. 431

15. OTHER DATE: QUAL. | MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LENA PARK MD | 17a. | 17b. NPI 1999999976

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES:

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

A. J03.83 | B. | C. | D. | E. | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE: | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24A. 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	04 15 26	04 15 26	11		99213		A	250.00	1		NPI	1999999976
2	04 15 26	04 15 26	11		85025		A	100.00	1		NPI	1999999976
3	04 15 26	04 15 26	11		80053		A	250.00	1		NPI	1999999976
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: SSN EIN: EIN [X] | 26. PATIENT'S ACCOUNT NO.: PT-04217 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 600.00 | 29. AMOUNT PAID: $ 30.00 | 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.): LENA PARK MD | SIGNATURE ON FILE | DATE:

32. SERVICE FACILITY LOCATION INFORMATION: ALDER CREEK MEDICAL GROUP, 1200 RIDGELINE DR STE 210, AUSTIN, TX 78731 | a. 1999999984 | b.

33. BILLING PROVIDER INFO & PH #: ( ) ALDER CREEK MEDICAL GROUP, 1200 RIDGELINE DR STE 210, AUSTIN, TX 78731 | a. 1999999984 | b.

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

GRITWORKS SYNTHETIC SAMPLE | NOT AN ISSUED RECORD | GW-IN-04217