CEDAR HEALTH PLAN
PO BOX 24170
AUSTIN, TX 78755

REF: CLM-260415-04217

HEALTH INSURANCE CLAIM FORM

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

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) 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	4. INSURED'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]	
5. PATIENT'S ADDRESS (No., Street): 4607 WILLOW BEND LN APT 204	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
	7. INSURED'S ADDRESS (No., Street): 4607 WILLOW BEND LN APT 204
CITY: AUSTIN STATE: TX	CITY: AUSTIN STATE: TX
ZIP CODE: 78731 TELEPHONE (Include Area Code): (512) 555 0146	ZIP CODE: 78731 TELEPHONE (Include Area Code): (512) 555 0146
8. RESERVED FOR NUCC USE	
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 [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER: GRP-04217	
a. INSURED'S DATE OF BIRTH MM DD YY: 08 19 1987 SEX M [ ] F [X]	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME: CEDAR CHOICE PPO	
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.
SIGNED: SIGNATURE ON FILE DATE: 04/15/2026

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 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 MM DD YY	
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 MM DD YY	
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. 0 A. R53.83 B. 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	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: 00-0042170 SSN [ ] 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 SIGNED: SIGNATURE ON FILE DATE: 04/16/26	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.		

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