Fax powered by DaisyBill

Original Bill - Fax Submission

To: Sedgwick Claims Management Services (TPA)
From: DaisyBill on the behalf of Harvey Group.
Attention: Ben Liscio

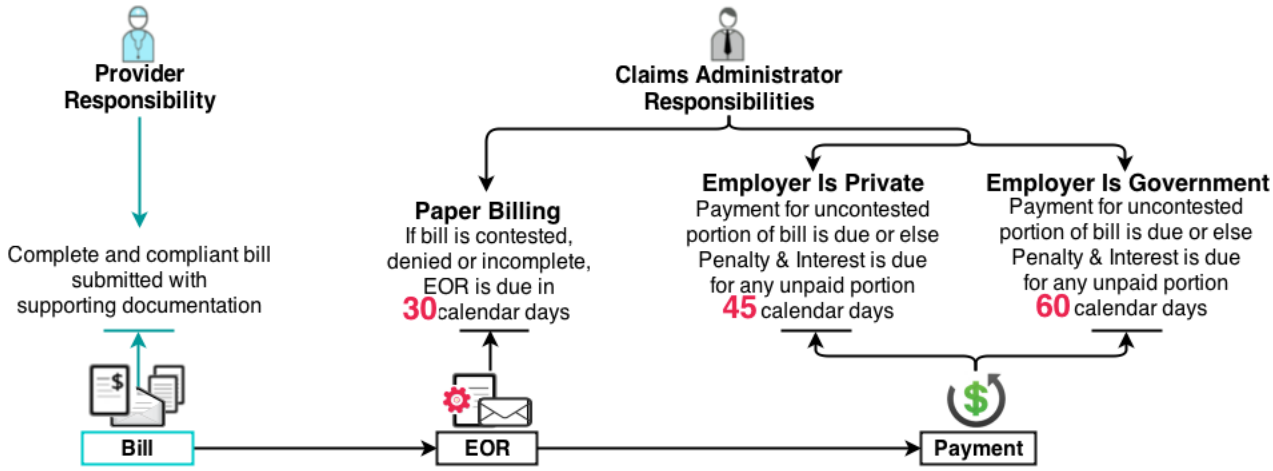
Patient Name: Delphine Cartwright **Patient Account Number**: 14db121974-1

DOS: 09/29/2014 **Charge**: $334.30

For billing and coding questions contact: Beatrice Reynolds at (612) 715-35828759

Documents included in this submission:
1) CMS 1500
2) Medical PermanentImpairment Report - JaoJjWE4R66Kx8pcrLwr_www.dir.ca.gov_dwc_FeeSchedules_PathologyLaboratory_FeeSchedule_PathologyLaborator_OrderApril2014.pdf
3) Admission Summary - pdf.pdf

Mandated Timeline
10/27/2014 - Original faxed to (347) 721-6884 from (646) 200-5744 at 11:14:30 AM PDT
11/26/2014 - Objections to bill due (30 calendar days)
12/11/2014 - Payment due in 45 calendar days (60 calendar days if employer is government)
12/11/2014 - Penalty and interest due for any unpaid portion of the bill 45 calendar days (60 calendar days if employer is government)



For more information on becoming e-billing compliant per (8 CCR § 9792.5.1(a)) effective 10/18/2012, please contact info@daisybill.com

HEALTH INSURANCE CLAIM FORM

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

PICA

Sedgwick Claims Management Services (TPA)
94566 Moen Wells
East Reese KY 90001-9998

CMS1500 Page 1 of 1

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
OTHER (ID#) X	222-22-2222
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CARTWRIGHT, DELPHINE	3. PATIENT'S BIRTH DATE MM DD YY: 02 22 55 — SEX: M ☐ F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): BOSCO GROUP	
5. PATIENT'S ADDRESS (No., Street): 586 DICKENS CRESCENT	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other X
7. INSURED'S ADDRESS (No., Street)	
CITY: MOSSIELAND — STATE: CA	8. RESERVED FOR NUCC USE
CITY — STATE	
ZIP CODE: 90001-9998 — TELEPHONE (Include Area Code): ( )	
ZIP CODE — TELEPHONE (Include Area Code): ( )	
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	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): X YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC): Y4 1068159125	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *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: 10/27/2014

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 22 11 QUAL.	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	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? X YES ☐ NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 9		22. RESUBMISSION CODE — ORIGINAL REF. NO.
A. 72700 B. C. D. / E. F. G. H. / I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 09 29 14	09 29 14	81		99215		A	334.30	1.0		ZZ	2086S0105X
										NPI	9524883157
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
710917477	X	14db121974-1	☐ YES ☐ NO	$ 334.30	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Signature on File — SIGNED; 10/27/2014 — DATE	Pagac, Russel and Lockman 72989 Keeling Meadow Karineside CA 90001-9998	Harvey Group 7287 Beatty Junction Port Jovani CA 90001-9998 (612) 715-35828759
	a. 1740269174 b.	a. 1740269174 b.

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