

1500

HEALTH

APPROVED BY N...

PICA

Complete only if you would like us to submit to insurance for you to get reimbursed. Please remember we are an out of network provider.

Claims Mailing Address found on back of insurance card:

<input type="checkbox"/> 1. MEDICARE (Medicare #)		<input type="checkbox"/> 2. MEDICAID (Medicaid #)		<input type="checkbox"/> 3. TRICARE CHAMPUS (Sponsor's SSN)		<input type="checkbox"/> 4. CHAMPVA (Member ID#)		<input type="checkbox"/> 5. GROUP HEALTH PLAN (SSN or ID)		<input type="checkbox"/> 6. FECA BLK LUNG (SSN)		<input type="checkbox"/> 7. OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)							
CITY			STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY			STATE				
ZIP CODE			TELEPHONE (Include Area Code) ()			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) <input type="checkbox"/> YES <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>				
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10j. RESERVED FOR LOCAL USE						c. INSURANCE PLAN NAME OR PROGRAM NAME							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>							
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.												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 _____						DATE _____						SIGNED _____							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____			17b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL BILL NO.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												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																NPI			
2																NPI			
3																NPI			
4																NPI			
5																NPI			
6																NPI			
25. FEDERAL TAX I.D. NUMBER 20-4690082				SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$					
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 # (702) 368-6429							
SIGNED _____						DATE 03 07 2011						a. _____							
Nevada Center for Behavior Thera 2620 Regatta Dr., Suite 102 Las Vegas NV 89128						Mark C. Anderson, PhD 2620 Regatta Dr. Suite 102 Las Vegas NV 89128													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION