HEALTH INSURANCE CLAIM FORM

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

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) KG-89933-Y77
2. PATIENT'S NAME (Last name, First Name, Middle Initial) McKenzie, Kate W.	3. PATIENT'S BIRTH DATE MM DD YY: 05 22 59 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) McKenzie, Kate W.
5. PATIENT'S ADDRESS (No., Street) 128 Summer Street, Apartment 6B	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 128 Summer Street, Apartment 6B
CITY: Waltham STATE: MA	8. RESERVED FOR NUCC USE	CITY: Waltham STATE: MA
ZIP CODE: 02452 TELEPHONE (Include Area Code): (781) 234-8763		ZIP CODE: 02452 TELEPHONE (Include Area Code): (781) 234-8763
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) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY: 05 22 1959 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 Network Blue
d. INSURANCE PLAN NAME OR PROGRAM NAME	d. 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 11/3/2014

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 Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.	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	17a. 17b. NPI	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 [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. 300.4 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 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. #
11	03	14	11	03	14	11		90834		A	$150.00	1		NPI	1755569309
11	04	14	11	04	14	11		90834		A	$150.00	1		NPI	1755569309
11	12	14	11	12	14	11		90834		A	$150.00	1		NPI	1755569309
11	13	14	11	13	14	11		90834		A	$150.00	1		NPI	1755569309
11	14	14	11	14	14	11		90834		A	$150.00	1		NPI	1755569309
11	17	14	11	17	14	11		90834		A	$150.00	1		NPI	1755569309

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES [X] NO [ ]	28. TOTAL CHARGE $ $900.00
29. AMOUNT PAID $ $0.00	30. Rsvd for NUCC		

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.) SIGNED MD, Ph. D. DATE 11/12/201	32. SERVICE FACILITY LOCATION INFORMATION 1477 Beacon Street, Suite 1603 Brookline, MA 02446 a. 1755569309 b.	33. BILLING PROVIDER INFO & PH# (617) 899-4513 Jane S. Holzmann, MD, Ph. D. 1477 Beacon Street, Suite 1603 Brookline, MA 02446 a. 1755569309 b.