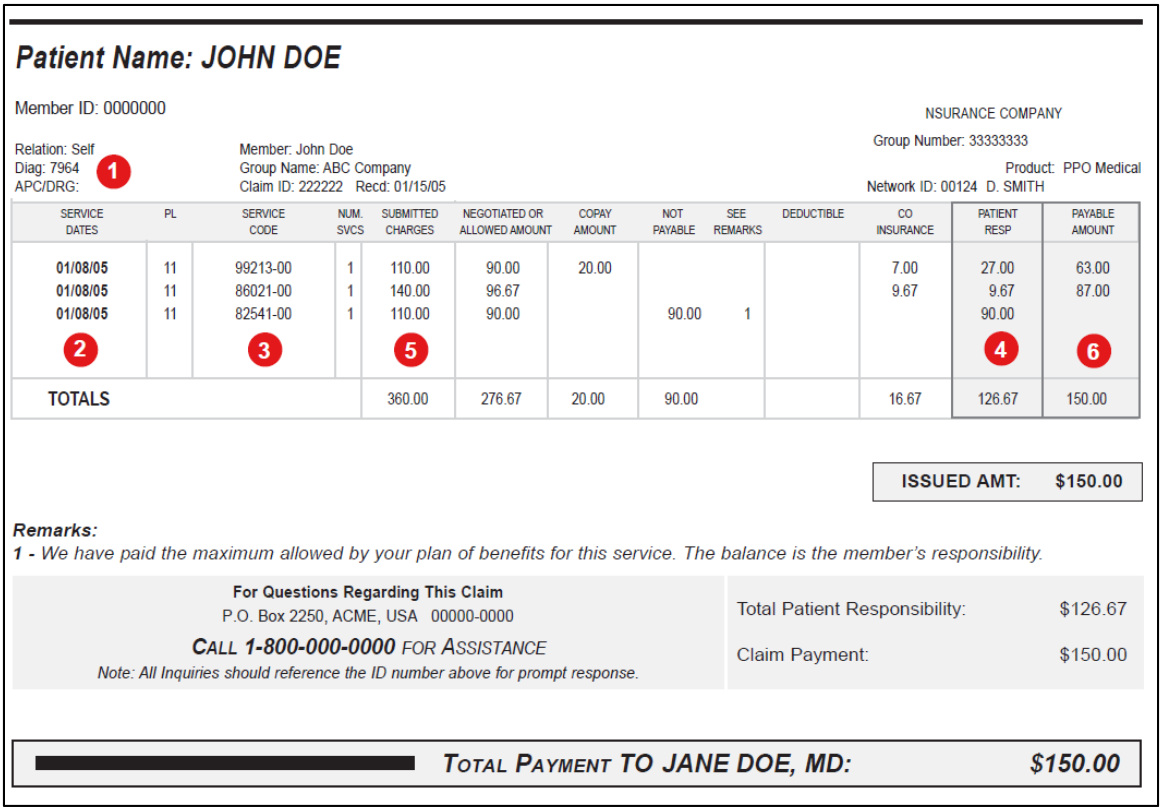
**Sample EOB:**



## *Patient Name: JOHN DOE*

Member ID: 0000000

NSURANCE COMPANY

Group Number: 33333333

Relation: Self
Diag: 7964
APC/DRG:

1

Member: John Doe
Group Name: ABC Company
Claim ID: 222222 Recd: 01/15/05

Product: PPO Medical
Network ID: 00124 D. SMITH

| SERVICE DATES | PL | SERVICE CODE | NUM. SVCS | SUBMITTED CHARGES | NEGOTIATED OR ALLOWED AMOUNT | COPAY AMOUNT | NOT PAYABLE | SEE REMARKS | DEDUCTIBLE | CO INSURANCE | PATIENT RESP | PAYABLE AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01/08/05 | 11 | 99213-00 | 1 | 110.00 | 90.00 | 20.00 | | | | 7.00 | 27.00 | 63.00 |
| 01/08/05 | 11 | 86021-00 | 1 | 140.00 | 96.67 | | | | | 9.67 | 9.67 | 87.00 |
| 01/08/05 | 11 | 82541-00 | 1 | 110.00 | 90.00 | | 90.00 | 1 | | | 90.00 | |
| 2 | | 3 | | 5 | | | | | | | 4 | 6 |
| TOTALS | | | | 360.00 | 276.67 | 20.00 | 90.00 | | | 16.67 | 126.67 | 150.00 |

**ISSUED AMT: $150.00**

***Remarks:***

***1 -*** *We have paid the maximum allowed by your plan of benefits for this service. The balance is the member's responsibility.*

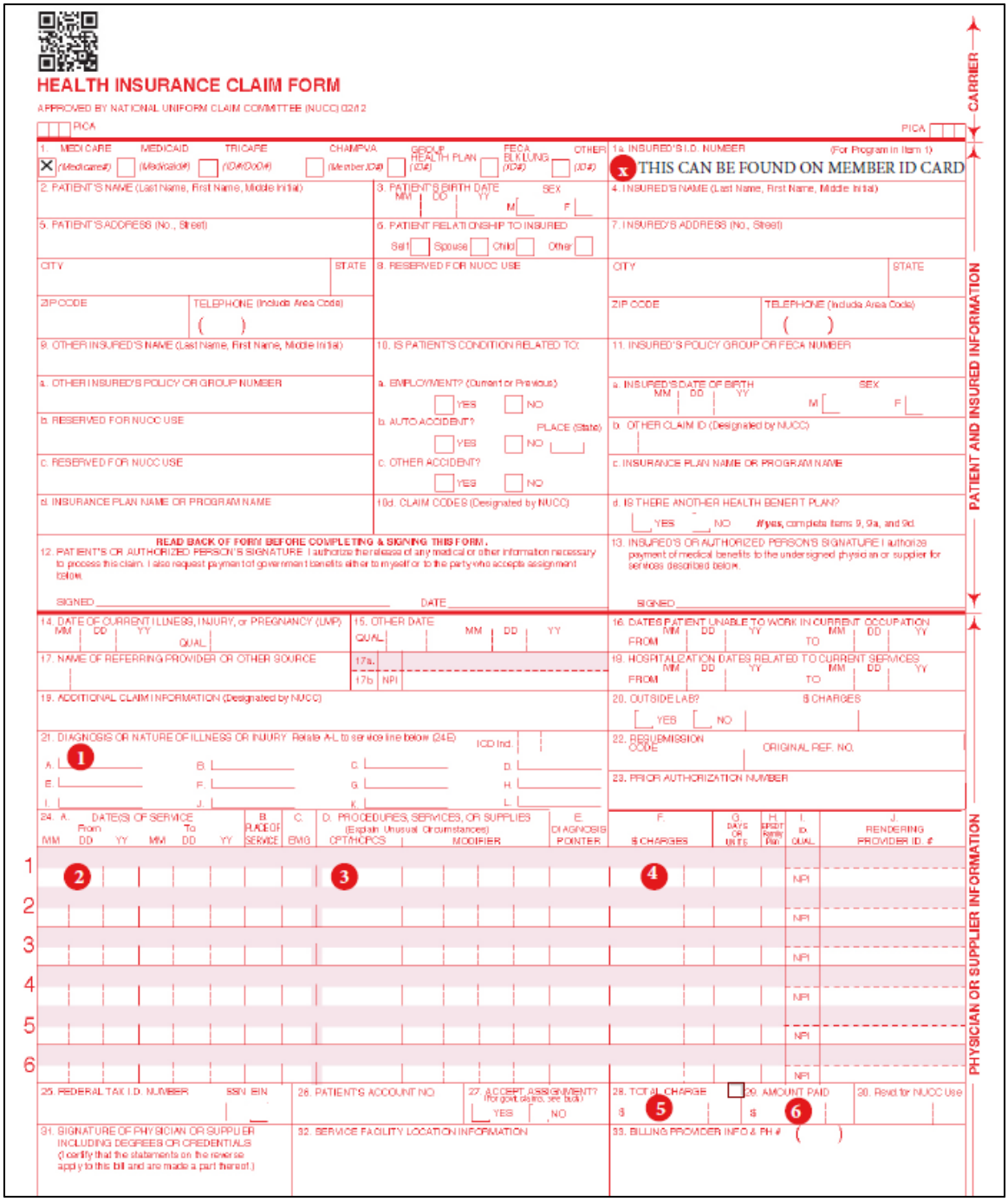
**For Questions Regarding This Claim**
P.O. Box 2250, ACME, USA 00000-0000
***CALL 1-800-000-0000 FOR ASSISTANCE***
*Note: All Inquiries should reference the ID number above for prompt response.*

Total Patient Responsibility: $126.67

Claim Payment: $150.00

***TOTAL PAYMENT TO JANE DOE, MD: $150.00***

**Sample HICFA:**



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#) FECA BLK LUNG (ID#) OTHER (ID#)

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

x THIS CAN BE FOUND ON MEMBER ID CARD

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE 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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

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 DATE

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 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

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

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.

1

A. 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 | 2 | | | 3 | | | 4 | | | NPI | |
| 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) YES NO

28. TOTAL CHARGE $ 5

29. AMOUNT PAID $ 6

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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

UPDATED MARCH 2016.