

**Fill in this information to identify the case:**

Debtor 1 Tehum Care Services, Inc.

Debtor 2 \_\_\_\_\_  
(Spouse, if filing)

United States Bankruptcy Court for the: Southern District of Texas

Case number 23-90086

**Official Form 410**  
**Proof of Claim**

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

**Part 1: Identify the Claim**

1. Who is the current creditor? Ada County Paramedics  
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor County of Ada

2. Has this claim been acquired from someone else?  
 No  
 Yes. From whom? \_\_\_\_\_

3. Where should notices and payments to the creditor be sent?  
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

<p><b>Where should notices to the creditor be sent?</b></p> <p><u>Ammon C. Taylor</u> Name</p> <p><u>200 W. Front St., Room 3191</u> Number Street</p> <p><u>Boise</u> ID <u>83702</u> City State ZIP Code</p> <p>Contact phone <u>208-287-7700</u></p> <p>Contact email _____</p>	<p><b>Where should payments to the creditor be sent? (if different)</b></p> <p><u>Ada County Paramedics</u> Name</p> <p><u>370 N. Benjamin Lane</u> Number Street</p> <p><u>Boise</u> ID <u>83704</u> City State ZIP Code</p> <p>Contact phone <u>208-287-2950</u></p> <p>Contact email _____</p>
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Uniform claim identifier for electronic payments in chapter 13 (if you use one):  
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4. Does this claim amend one already filed?  
 No  
 Yes. Claim number on court claims registry (if known) \_\_\_\_\_ Filed on \_\_\_\_\_  
MM / DD / YYYY

5. Do you know if anyone else has filed a proof of claim for this claim?  
 No  
 Yes. Who made the earlier filing? \_\_\_\_\_

RECEIVED

AUG 10 2023

KURTZMAN CARSON CONSULTANTS



**Part 2: Give Information About the Claim as of the Date the Case Was Filed**

6. Do you have any number you use to identify the debtor?  No  
 Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: \_\_\_\_\_

7. How much is the claim? \$ 84,225.61. Does this amount include interest or other charges?  
 No  
 Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.  
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).  
Limit disclosing information that is entitled to privacy, such as health care information.  
Ambulance Services

9. Is all or part of the claim secured?  No  
 Yes. The claim is secured by a lien on property.  
**Nature of property:**  
 Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.  
 Motor vehicle  
 Other. Describe: \_\_\_\_\_  
**Basis for perfection:** \_\_\_\_\_  
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)  
**Value of property:** \$ \_\_\_\_\_  
**Amount of the claim that is secured:** \$ \_\_\_\_\_  
**Amount of the claim that is unsecured:** \$ \_\_\_\_\_ (The sum of the secured and unsecured amounts should match the amount in line 7.)

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AUG 10 2023  
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Amount necessary to cure any default as of the date of the petition: \$ \_\_\_\_\_

Annual Interest Rate (when case was filed) \_\_\_\_\_ %  
 Fixed  
 Variable

10. Is this claim based on a lease?  No  
 Yes. Amount necessary to cure any default as of the date of the petition. \$ \_\_\_\_\_

11. Is this claim subject to a right of setoff?  No  
 Yes. Identify the property: \_\_\_\_\_

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

No

Yes. Check one:

Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

Up to \$3,350\* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).

Wages, salaries, or commissions (up to \$15,150\*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).

Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).

Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).

Other. Specify subsection of 11 U.S.C. § 507(a)( ) that applies.

Amount entitled to priority

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

**Part 3: Sign Below**

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

I am the creditor.

I am the creditor's attorney or authorized agent.

I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 8/14/2023

MM / DD / YYYY

Signature

Print the name of the person who is completing and signing this claim:

Name: Rod Beck  
First name Middle name Last name

Title: Chairman, Board of Ada County Emergency Medical Services District

Company: Ada County Paramedics  
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 370 N. Benjamin Lane  
Number Street

Boise ID 83704  
City State ZIP Code

Contact phone: 208-287-2950 Email: \_\_\_\_\_

RECEIVED  
 AUG 10 2023

KURTZMAN CARSON CONSULTANTS

Print

Save As...

Add Attachment

Reset



**ADA COUNTY PROSECUTING ATTORNEY  
JAN M. BENNETTS**

**Criminal Division**

200 W. Front Street, Rm 3191  
Boise, Idaho 83702

Phone (208) 287-7700  
Fax (208) 287-7709

**Civil Division**

200 W. Front Street, Rm 3191  
Boise, Idaho 83702

Phone (208) 287-7700  
Fax (208) 287-7719

**Juvenile Division**

6300 Denton Street  
Boise, Idaho 83704

Phone (208) 577-4900  
Fax (208) 577-4909

August 4, 2023

*VIA U.S. MAIL*

Tehum Care Services, Inc. Claims Processing Center  
c/o KCC  
222 N. Pacific Coast Hwy., Ste. 300  
El Segundo, CA 90245

RE: Chapter 11 Case No. 23-90086  
U.S. Bankruptcy Court – Southern District of Texas (Houston Division)

Dear Claims Agent:

I am enclosing an original Proof of Claim, to be filed in the above referenced Chapter 11 bankruptcy.

Please add the Ada County Paramedics to the Mailing Matrix for this case. The mailing address is Ada County Paramedics c/o Ammon C. Taylor, 200 W. Front Street, Rm. 3191, Boise, ID 83702.

If you need any additional information, feel free to contact me at (208) 287-7700.

Sincerely,

**JAN M. BENNETTS**

Ada County Prosecuting Attorney

Ammon C. Taylor  
Deputy Prosecuting Attorney

JMB:ACT:sr

Encl.

cc: Gray Reed & McGraw LLP, Debtor's Counsel  
Berger Singerman LLP, Debtor's Counsel  
O'Connor Kimball LLP, Debtor's Counsel



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>	PICA <input type="checkbox"/>
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>85ID</b>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Dunlap Timothy A</b>	3. PATIENT'S BIRTH DATE MM DD YY <b>1968</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TMSI Max Security</b>	5. PATIENT'S ADDRESS (No., Street) <b>13400 S Pleasant Valley Rd</b>
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) <b>ATTEN DIANNA</b>
8. RESERVED FOR NUCC USE	CITY STATE ID <b>Boise ID</b>
CITY STATE ID <b>Kuna ID</b>	ZIP CODE TELEPHONE (Include Area Code) <b>83707 (208) 389-0230</b>
ZIP CODE TELEPHONE (Include Area Code) <b>83634 (208) 338-1635</b>	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.	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 <u>SIGNATURE ON FILE</u> DATE <u>07 12 2021</u>
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL <b>07 12 2021 QUAL 431</b>	15. OTHER DATE MM DD YY QUAL
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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b> A. <b>R079</b> B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER <b>83634-2716</b>
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. IEP/ST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#	25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 28. TOTAL CHARGE \$ 1326.63 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use
1. <b>07122021 07122021 41 Y A0427 EH A 1140.47 1 NPI</b>	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.) <b>ADA County Paramedics</b> 05 10 2023
2. <b>07122021 07122021 41 Y A0425 EH A 186.16 13.0 NPI</b>	32. SERVICE FACILITY LOCATION INFORMATION FROM: <b>13400 S Pleasant Valley Rd Kuna, ID 83634-2716</b> TO: <b>1055 N Curtis Road Boise, ID 83704-1309</b>
3. NPI	33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b>
4. NPI	SIGNED DATE
5. NPI	SIGNED DATE
6. NPI	SIGNED DATE

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 68ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Storey Gregory S		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO	
3. PATIENT'S BIRTH DATE MM DD YY 1949 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL	
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY STATE ID Boise ID		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)	
CITY STATE ID Boise ID		11. INSURED'S POLICY GROUP OR FECA NUMBER 1607	
ZIP CODE TELEPHONE (Include Area Code) 83705 (208) 331-1195		a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. OTHER CLAIM ID (Designated by NUCC)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
b. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
c. RESERVED FOR NUCC USE		12. PATIENT'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 DATE 07 12 2021	
d. INSURANCE PLAN NAME OR PROGRAM NAME		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 07 12 2021 QUAL 431		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service-line below (24E)) A. R4182 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634	
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 OF UNITS H. ICD-9/10 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>	
1. 07122021 07122021 41 Y A0427 EH A 1205 18 1 NPI		26. PATIENT'S ACCOUNT NO. 975A 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. 07122021 07122021 41 Y A0425 EH A 196 18 13.7 NPI		28. TOTAL CHARGE \$ 1401.36 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use	
3. NPI		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.) ADA County Paramedics 05 10 2023	
4. NPI		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	
5. NPI		33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498	
6. NPI		SIGNED DATE Boise, ID 83704-1309 9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medical#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 07 ID																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ROBERTS MICHAEL D						3. PATIENT'S BIRTH DATE MM DD YY 1989 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX						4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter																							
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL																							
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE			CITY Boise			STATE ID																							
ZIP CODE 83634			TELEPHONE (Include Area Code) (208) 629-8783			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX																							
b. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)																							
c. RESERVED FOR NUCC USE						d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon						c. INSURANCE PLAN NAME OR PROGRAM NAME																							
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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												12. PATIENT'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 DATE 07-14-2021												SIGNED SIGNATURE ON FILE																							
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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/HCP/CS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSON Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #														
1 07/14/2021 07/14/2021 41 Y			A0427		EH		A				978.15		1		NPI		NPI		NPI																
2 07/14/2021 07/14/2021 41 Y			A0425		EH		A				189.02		13.2		NPI		NPI		NPI																
3			NPI		NPI		NPI				NPI		NPI		NPI		NPI		NPI																
4			NPI		NPI		NPI				NPI		NPI		NPI		NPI		NPI																
5			NPI		NPI		NPI				NPI		NPI		NPI		NPI		NPI																
6			NPI		NPI		NPI				NPI		NPI		NPI		NPI		NPI																
25. FEDERAL TAX I.D. NUMBER 0277						26. PATIENT'S ACCOUNT NO. 204A						27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						28. TOTAL CHARGE \$ 1167.17						29. AMOUNT PAID \$ 0.00						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.) ADA County Paramedics												32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309												33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498											
SIGNED DATE 05 10 2023												a. 9987 b.																							

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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**HEALTH INSURANCE CLAIM FORM**

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PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (IC#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 4429									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Maki Tawny L.										3. PATIENT'S BIRTH DATE MM DD YY 1991 M <input type="checkbox"/> F <input checked="" type="checkbox"/> SEX									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) PRISON DOC WOMENS										5. PATIENT'S ADDRESS (No., Street) 733 W Ramsbrook St									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTEN LARRY HEINZ									
8. RESERVED FOR NUCC USE					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Maki Tawny L.					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon				
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 08 08 2021					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 08 08 2021 QUAL 431					15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0									
22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 83712									
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. EPSTD Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>									
26. PATIENT'S ACCOUNT NO. 986A										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
28. TOTAL CHARGE \$ 1132.66										29. AMOUNT PAID \$ 0.00									
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.) ADA County Paramedics 05 10 2023									
32. SERVICE FACILITY LOCATION INFORMATION FROM: 2366 E Old Penitentiary Rd Boise, ID 83712 TO: 190 E Bannock Street Boise, ID 83712-6241										33. BILLING PROVIDER INFO & PH# (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER	1a. INSURED'S I.D. NUMBER 84 ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Ferguson Robert R</b>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TCC ID Correction Center</b>
3. PATIENT'S BIRTH DATE <b>1964</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b>
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>	8. RESERVED FOR NUCC USE
CITY: <b>Kuna</b> STATE: <b>ID</b> ZIP CODE: <b>83634</b> TELEPHONE (Include Area Code): <b>( )</b>	CITY: <b>Boise</b> STATE: <b>ID</b> ZIP CODE: <b>83707</b> TELEPHONE (Include Area Code): <b>(208) 331-2760</b>
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 checked="" type="checkbox"/> NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
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 <b>SIGNATURE ON FILE</b> DATE <b>05 31 2021</b>	17. INSURED'S POLICY GROUP OR FECA NUMBER <b>Corizon</b>
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) <b>05 31 2021</b> QUAL <b>431</b>	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	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: <b>0</b>	22. RESUBMISSION CODE ORIGINAL REF. NO.
A <b>R079</b> B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER <b>83634</b>
24. A. DATE(S) OF SERVICE From To 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. #	PHYSICIAN OR SUPPLIER INFORMATION
1. <b>05312021 05312021 41 Y A0427 SH A 1042 86 1 NPI</b>	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.) <b>ADA County Paramedics</b>
2. <b>05312021 05312021 41 Y A0425 SH A 189 02 13.2 NPI</b>	32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>
3. NPI	33. BILLING PROVIDER INFO & PH# <b>(208) 287 2950</b>
4. NPI	25. FEDERAL TAX I.D. NUMBER <b>0277</b> <input checked="" type="checkbox"/> SSN EIN <b>602A</b> <input checked="" type="checkbox"/>
5. NPI	26. PATIENT'S ACCOUNT NO. <b>602A</b> 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
6. NPI	28. TOTAL CHARGE \$ <b>1231 88</b> 29. AMOUNT PAID \$ <b>0 00</b> 30. Rsvd for NUCC Use
SIGNED DATE <b>Boise, ID 83704-1309</b>	9987

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TAYLOR TYLER N						3. PATIENT'S BIRTH DATE MM DD YY 1986 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter			
5. PATIENT'S ADDRESS (No. Street) 14601 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No. Street) ATTEN MEDICAL			
CITY Kuna			STATE	8. RESERVED FOR NUCC USE	CITY Boise			STATE ID		
ZIP CODE 83634	TELEPHONE (Include Area Code) ( )		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	ZIP CODE 83707	TELEPHONE (Include Area Code) (208) 331-2760				
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. RESERVED FOR NUCC USE	c. RESERVED FOR NUCC USE	d. INSURANCE PLAN NAME OR PROGRAM NAME	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	10d. CLAIM CODES (Designated by NUCC)	11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. INSURED'S DATE OF BIRTH MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. OTHER CLAIM ID (Designated by NUCC)	c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	d. IS THERE ANOTHER HEALTH-BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO #yes, complete items 9, 9a, and 9d.	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 06-02-2021					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 02 2021	QUAL 431	15. OTHER 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. NPI	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. I55	B.	C.	D.	E.	F.	G.	H.	I.		
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	06022021	06022021	41	Y	A0427	SH	A	1140.47	1	NPI
2	06022021	06022021	41	Y	A0425	SH	A	189.02	13.2	NPI
3										NPI
4										NPI
5										NPI
6										NPI
25. FEDERAL TAX I.D. NUMBER 0277	SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 844A	27. ACCEPT ASSIGNMENT? (For opt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 1329.49	29. AMOUNT PAID \$ 0.00	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.) ADA County Paramedics	32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA	<input type="checkbox"/> PICA																																																																																			
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLX LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 911D																																																																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Shakespeare Justin A					3. PATIENT'S BIRTH DATE MM DD YY 1982 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter																																																																										
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) ( )					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760																																																																										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																																																																										
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																																																																										
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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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD ind. 0 A. R079 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																										
23. PRIOR AUTHORIZATION NUMBER 83634																																																																																				
<table border="1"> <thead> <tr> <th>24. A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C. EMG</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>E. DIAGNOSIS POINTER</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. FRS/DI Family Pkg</th> <th>I. ID. QUAL</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>06022021</td> <td>06022021</td> <td>41</td> <td>Y A0427 SH</td> <td>A</td> <td>1140 47</td> <td>1</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>06022021</td> <td>06022021</td> <td>41</td> <td>Y A0425 SH</td> <td>A</td> <td>189 02.13.2</td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> </tbody> </table>															24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. FRS/DI Family Pkg	I. ID. QUAL	J. RENDERING PROVIDER ID. #	06022021	06022021	41	Y A0427 SH	A	1140 47	1		NPI		06022021	06022021	41	Y A0425 SH	A	189 02.13.2			NPI										NPI										NPI										NPI										NPI	
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25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 881A					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																										
28. TOTAL CHARGE \$ 1329 49					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 21 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309					33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																																																																					
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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input checked="" type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (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	
LOFTHOUSE TRAVIS C						1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
14601 S Pleasant Valley Rd				Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		LOFTHOUSE TRAVIS C	
CITY		STATE		8. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street)	
Kuna		ID				14601 S Pleasant Valley Rd	
ZIP CODE		TELEPHONE (Include Area Code)				CITY	
83634		(208) 270-9694				Kuna ID	
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	
LOFTHOUSE TRAVIS C				a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH MM DD YY	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME				c. OTHER ACCIDENT? PLACE (State)		Corizon	
Select Health				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
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.)				10d. CLAIM CODES (Designated by NUCC)		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
SIGNED SIGNATURE ON FILE				DATE 06-03-2021		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE MM DD YY		SIGNED SIGNATURE ON FILE	
06 03 2021 QUAL 431							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD ind. 0				22. RESUBMISSION CODE ORIGINAL REF. NO.		20. OUTSIDE LAB? \$ CHARGES	
A. IZ889 B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER		<input type="checkbox"/> YES <input type="checkbox"/> NO	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE		22. RESUBMISSION CODE ORIGINAL REF. NO.	
06032021 06032021				41 Y		23. PRIOR AUTHORIZATION NUMBER	
C. EMG				D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		83634	
Y				A0427 EH A		20. OUTSIDE LAB? \$ CHARGES	
1				AMBULANCE SERVICE - ALS1		1003 62 1	
2				MILEAGE		NPI	
06032021 06032021				41 Y		2	
3				A0425 EH A		NPI	
4						3	
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)	
0277		<input type="checkbox"/> <input checked="" type="checkbox"/>		232A		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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		28. TOTAL CHARGE	
ADA County Paramedics				FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634		\$ 1191 21	
04 21 2023				TO: 1055 N Curtis Road Boise, ID 83704-1309		\$ 0 00	
SIGNED DATE				33. BILLING PROVIDER INFO & PH #		29. AMOUNT PAID	
				ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498		30. Rsvd for NUCC Use	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 64ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Joyce Jourdan										3. PATIENT'S BIRTH DATE (MM DD YY) 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Joyce Jourdan										5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
CITY Kuna					STATE ID					CITY Kuna					STATE ID				
ZIP CODE 83634					TELEPHONE (Include Area Code) ( )					ZIP CODE 83634					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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH (MM DD YY) 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										12. PATIENT'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										SIGNED SIGNATURE ON FILE									
DATE 06-05-2021										DATE 06-05-2021									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 05 2021 QUAL 431										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. R079 B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER 83634									
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. ICD-9-CM Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 06052021 06052021		41		Y		A0427 SH		A		1140.47		1		NPI					
2 06052021 06052021		41		Y		A0425 SH		A		196.18		13.7		NPI					
3														NPI					
4														NPI					
5														NPI					
6														NPI					
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 341A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1336.65									
29. AMOUNT PAID \$ 0.00										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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
SIGNED DATE 04 21 2023										33. BILLING PROVIDER INFO & PH # (208) 287 2950									
										Boise ID 83704-8498									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA B/L LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Anderson Drew		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter	
3. PATIENT'S BIRTH DATE MM DD YY: 1992 M X F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL	
5. PATIENT'S ADDRESS (No., Street) 14195 Pleasant Valley Road		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street) Boise		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
8. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER 1607	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		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	
b. RESERVED FOR NUCC USE		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 07 2021 QUAL: 431	
c. RESERVED FOR NUCC USE		15. OTHER DATE MM DD YY	
d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
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: 06 07 2021		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: 0		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
A. R55 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
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) EPT/HOPCS MODIFIER E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER 83634	
1. 06072021 06072021 41 Y A0998 A		F. \$ CHARGES 408 45 G. DAYS OR UNITS 1 H. EPSDT Family Plan I. ID. QUAL NPI J. RENDERING PROVIDER ID #	
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 605A	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 408 45	
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 21 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634	
33. BILLING PROVIDER INFO & PH # (208) 287 2950		Boise ID 83704-8498	
SIGNED DATE		a. 9987 b.	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LUNG) <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 74 ID																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Osborn David A										3. PATIENT'S BIRTH DATE MM/DD/YY 1948 M <input checked="" type="checkbox"/> F <input type="checkbox"/>																													
4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO										5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd																													
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL																													
CITY Kuna					STATE ID					CITY Boise					STATE ID																								
ZIP CODE 83634					TELEPHONE (Include Area Code) ( )					ZIP CODE 83707					TELEPHONE (Include Area Code) (208) 331-1195																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
11. INSURED'S POLICY GROUP OR FECA NUMBER 74										a. INSURED'S DATE OF BIRTH MM/DD/YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>																													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)																													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
d. INSURANCE PLAN NAME OR PROGRAM NAME Centurion of ID IDOC										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																													
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 06-08-2021																				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 06/08/2021 QUAL 431										15. OTHER DATE MM/DD/YY																													
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY										17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY																													
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																													
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0																													
A. R0602										B. _____ C. _____ D. _____																													
E. _____ F. _____ G. _____ H. _____										I. _____ J. _____ K. _____ L. _____																													
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) OPT/HPCS MODIFIER																													
E. DIAGNOSIS POINTER										F. \$ CHARGES																													
G. DAYS OR UNITS										H. EPSDT Family Plan																													
I. ID. QUAL										J. RENDERING PROVIDER ID. #																													
1. 06082021 06082021 41 Y A0427 EH A 1042 86 1 NPI										AMBULANCE SERVICE - ALS1																													
2. 06082021 06082021 41 Y A0425 EH A 196 18 13.7 NPI										MILEAGE																													
3. _____ NPI																																							
4. _____ NPI																																							
5. _____ NPI																																							
6. _____ NPI																																							
25. FEDERAL TAX I.D. NUMBER 0277										26. PATIENT'S ACCOUNT NO. 766A																													
27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1239.04																													
29. AMOUNT PAID \$ 0.00										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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309																													
33. BILLING PROVIDER INFO & PH# (208) 287 2950										ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																													
SIGNED _____ DATE 04 21 2023										9987																													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 05ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harvey Richard										3. PATIENT'S BIRTH DATE MM DD YY 1975 M x F									
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) ( )										7. INSURED'S ADDRESS (No., Street) ATTEN: MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760									
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH MM DD YY M x F									
12. PATIENT'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 DATE 06 11 2021										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 06 11 2021 QUAL 431										15. OTHER DATE MM DD YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD ind. 0 A. LI10 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER 83634										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. ICD-10 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#									
1. 06112021 06112021 41 Y A0427 SH A 978 15 1 NPI										2. 06112021 06112021 41 Y A0425 SH A 189 02 13.2 NPI									
3. NPI										4. NPI									
5. NPI										6. NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 155A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1167.17 29. AMOUNT PAID \$ 0.00 30. Rev'd 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.) ADA County Paramedics 04 21 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise, ID 83704-8498 9987																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 27ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>RIVAS JUSTIN</b>		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 1994 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b> CITY: <b>Kuna</b> STATE: <b>ID</b> ZIP CODE: <b>83634</b> TELEPHONE (Include Area Code): <b>( )</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>RIVAS JUSTIN</b>	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b> CITY: <b>Kuna</b> STATE: <b>ID</b> ZIP CODE: <b>83634</b> TELEPHONE (Include Area Code): <b>( )</b>	
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 checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 1994 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
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: _____		b. OTHER CLAIM ID (Designated by NUCC)	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) QUAL: <b>431</b>		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>	
15. OTHER DATE (MM/DD/YY) QUAL: _____		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		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: _____	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM: _____ TO: _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/DD/YY) FROM: _____ TO: _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM: _____ TO: _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: <b>0</b>		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
A. <b>IR55</b> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.:	
24. A. DATE(S) OF SERVICE From: <b>04/08/2021</b> To: <b>04/08/2021</b> PLACE OF SERVICE: <b>41</b> B. _____ C. _____		23. PRIOR AUTHORIZATION NUMBER <b>83634</b>	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS: <b>A0429</b> MODIFIER: <b>EH</b> E. DIAGNOSIS POINTER: <b>A</b>		F. \$ CHARGES: <b>660.94</b> G. DAYS OR UNITS: <b>1</b> H. EPST/Fluorid/Plan: _____ I. ID. QUAL: <b>NPI</b> J. RENDERING PROVIDER ID. #: _____	
1. <b>AMBULANCE SERVICE - BLS</b>		2. <b>MILEAGE</b>	
2. <b>04/08/2021 04/08/2021 41 Y A0425 EH A 194.75 13.6 NPI</b>		3. _____ NPI: _____	
3. _____ NPI: _____		4. _____ NPI: _____	
4. _____ NPI: _____		5. _____ NPI: _____	
5. _____ NPI: _____		6. _____ NPI: _____	
25. FEDERAL TAX I.D. NUMBER: <b>0277</b> SSN EIN: <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO.: <b>306A</b>	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>855.69</b> 29. AMOUNT PAID \$ <b>0.00</b> 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.) <b>ADA County Paramedics</b> SIGNED: _____ DATE: <b>04 19 2023</b>		32. SERVICE FACILITY LOCATION INFORMATION FROM: <b>13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> TO: <b>1055 N Curtis Road Boise, ID 83704-1309</b>	
33. BILLING PROVIDER INFO & PH# <b>(208) 287 2950</b>		33. BILLING PROVIDER INFO & PH# <b>ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498</b> SIGNED: _____ DATE: <b>09987</b>	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK/LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 55 ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hofer Scott	3. PATIENT'S BIRTH DATE MM DD YY 1957 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID Correction Center	5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) ATEN MEDICAL
8. RESERVED FOR NUCC USE	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon
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 09 2021	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 04 09 2021 QUAL 431	15. OTHER DATE QUAL 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. NPI 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. ICD Ind. 0 A. IM79605 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO. 83634	23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. 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. #	25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>
26. PATIENT'S ACCOUNT NO. 467A	27. ACCEPT ASSIGNMENT? (for gov. claims see back) YES <input checked="" type="checkbox"/> NO
28. TOTAL CHARGE \$ 1329.49	29. AMOUNT PAID \$ 0.00
30. Rcvd 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.) ADA County Paramedics 04 19 2023
32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 051D																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith Randolph O						3. PATIENT'S BIRTH DATE MM DD YY 1959 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCIT IDAHO																						
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Road						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL																						
CITY Kuna		STATE ID		8. RESERVED FOR NUCC USE		CITY Boise		STATE ID		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 83707																	
ZIP CODE 83634		TELEPHONE (Include Area Code) (208) 375-0201		10. IS PATIENT'S CONDITION RELATED TO: b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10. IS PATIENT'S CONDITION RELATED TO: c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10. IS PATIENT'S CONDITION RELATED TO: 10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER 83707		11. INSURED'S POLICY GROUP OR FECA NUMBER (208) 333-1195		11. INSURED'S POLICY GROUP OR FECA NUMBER																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon		a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																	
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 05-25-2021		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 05 25 2021 QUAL 431		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. RESUBMISSION CODE ORIGINAL REF. NO.															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER 83634		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. ICD-9-CM Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
1	05252021	05252021	41	Y	A0427	EH	A	986.64	1	NPI																				
2	05252021	05252021	41	Y	A0425	EH	A	196.18	13.7	NPI																				
3										NPI																				
4										NPI																				
5										NPI																				
6										NPI																				

25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 802A		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1182.82		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics 04 19 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 73 ID																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hassan Mohammed A										3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] 1964 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 895-0459										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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 07 03 2021										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits for 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 07 03 2021 QUAL 431										15. OTHER DATE MM DD YY QUAL										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. NPI 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [REDACTED]									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. I639 B. C. D. E. F. G. H. I. J. K. L. ICD Ind: 0										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
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. EPSD (Only PH) I. ID. QUAL J. RENDERING PROVIDER ID.#										1. AMBULANCE SERVICE - ALS1 07032021 07032021 41 Y A0427 EH A 1140 47 1 NPI										2. MILEAGE 07032021 07032021 41 Y A0425 EH A 196 18 13.7 NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN [REDACTED] 0277 [REDACTED] X										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [REDACTED] 563A [REDACTED] YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1336 65 29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 19 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program In Item 1) 32 ID	
2. PATIENT'S NAME (Last Name; First Name, Middle Initial) Taylor Anita M		3. PATIENT'S BIRTH DATE MM DD YY 1962 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. INSURED'S NAME (Last Name; First Name, Middle Initial) Taylor Anita M		5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd	
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name; First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
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 09-24-2021		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to this undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 24 2021 QUAL 431		15. OTHER DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.	
22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER 83634-0000	
24. A. DATE(S) OF SERVICE From To MM DD YY 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 OF UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>	
26. PATIENT'S ACCOUNT NO. 337A		27. ACCEPT ASSIGNMENT? (For govt. claims see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. TOTAL CHARGE \$ 1336.65		29. AMOUNT PAID \$ 0.00	
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.) ADA County Paramedics 04 19 2023	
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLX LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 14 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Knibbe Jordan J						3. PATIENT'S BIRTH DATE MM DD YY 1998 M X F			4. INSURED'S NAME (Last Name, First Name, Middle Initial) TMST Max Security														
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA														
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE			CITY Boise			STATE ID											
ZIP CODE 83634			TELEPHONE (Include Area Code) ( )						ZIP CODE 83707			TELEPHONE (Include Area Code) (208) 389-0230											
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M X F											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.											
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 04-10-2021												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 04 10 2021 QUAL 431						15. OTHER DATE QUAL 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. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. UT1491XA ICD Ind 0												22. RESUBMISSION CODE ORIGINAL REF. NO.											
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. FRSOT Family Pkg I. ID. QUAL J. RENDERING PROVIDER ID. #												23. PRIOR AUTHORIZATION NUMBER 83634-2716											
1. 04102021 04102021 41 Y A0427 EH A 978 15 1 NPI																							
2. 04102021 04102021 41 Y A0425 EH A 186 16 13 0 NPI																							
3. NPI																							
4. NPI																							
5. NPI																							
6. NPI																							
25. FEDERAL TAX I.D. NUMBER 0277						26. PATIENT'S ACCOUNT NO. 602A						27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
28. TOTAL CHARGE \$ 1164.31						29. AMOUNT PAID \$ 0.00						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.) ADA County Paramedics 04 20 2023												32. SERVICE-FACILITY LOCATION INFORMATION FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA											PICA				
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input checked="" type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (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		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
Weaver Tyler A						MM DD YY 1988		M <input checked="" type="checkbox"/> F <input type="checkbox"/>		ICC ID CorrecCenter					
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)							
14601 S Pleasant Valley Rd						Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		ATTEN MEDICAL							
CITY		STATE		8. RESERVED FOR NUCC USE		CITY		STATE		ID					
Kuna		ID				Boise		ID							
ZIP CODE		TELEPHONE (Include Area Code)				ZIP CODE		TELEPHONE (Include Area Code)							
83634		(208) 587-5180				83707		(208) 331-2760							
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)		a. INSURED'S DATE OF BIRTH		SEX					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY		M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated by NUCC)							
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME							
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Corizon							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?							
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
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						DATE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)						15. OTHER DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
MM DD YY 04 10 2021 QUAL 431						QUAL			MM DD YY FROM TO						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a.	17b. NP?	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
								MM DD YY FROM TO							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB?			\$ CHARGES						
						<input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)						ICD Ind: 0			22. RESUBMISSION CODE						
A. G8911									ORIGINAL REF. NO.						
B. _____															
C. _____															
D. _____															
E. _____															
F. _____															
G. _____															
H. _____															
I. _____															
J. _____															
K. _____															
L. _____															
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
From		To													
MM DD YY		MM DD YY		MM DD YY	MM DD YY	MM DD YY	CPT/HCPCS		MODIFIER	POINTER					
04102021		04102021		41	Y	A0427	SH			A	1216 85	1	NPI		
04102021		04102021		41	Y	A0425	SH			A	190 46	13.3	NPI		
													NPI		
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Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 931D	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Shelly Carl D		3. PATIENT'S BIRTH DATE (MM DD YY) SEX 1979 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 876-4597		4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter 7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)	
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: 04-12-2021		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 12 2021 QUAL: 431		15. OTHER DATE (MM DD YY) QUAL: 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. ICD-10 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below [24E]) A. I549 B. C. D. E. F. G. H. I. J. K. L. ICD Ind: 0		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634	
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. ICD-10 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#		25. FEDERAL TAX I.D. NUMBER: 0277 <input checked="" type="checkbox"/> SSN EIN: <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO.: 829A 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE: \$ 1172.47 29. AMOUNT PAID: \$ 0.00 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.) ADA County Paramedics 04 20 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N. Curtis Road Boise, ID 83704-1309	
33. BILLING PROVIDER INFO & PH# (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498		34. SIGNED: DATE: 04 20 2023 35. SIGNED: DATE: 04 20 2023	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 35TD					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mocaby Michael L				3. PATIENT'S BIRTH DATE MM DD YY 1953 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Mocaby Michael L						
5. PATIENT'S ADDRESS (No., Street) 4802 Layton Ave CITY: Caldwell STATE: ID ZIP CODE: 83607 TELEPHONE (Include Area Code): (208) 899-0230				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 4802 Layton Ave CITY: Caldwell STATE: ID ZIP CODE: 83607 TELEPHONE (Include Area Code): (208) 899-0230						
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 1953 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State):		b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.						
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 13 2021						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 04 13 2021 QUAL 431			15. OTHER DATE MM DD YY QUAL			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. NPI	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. M25511 B. C. D. ICD ind: 0 E. F. G. H. I. J. K. L.						22. RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER 83634												
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 POINTNER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1 04132021 04132021		41	Y	AMBULANCE SERVICE - ALS1 A0427 SH		A	1042.86	1	NPI			
2 04132021 04132021		41	Y	MILEAGE A0425 SH		A	187.59	13.1	NPI			
3									NPI			
4									NPI			
5									NPI			
6									NPI			
25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 998A		27. ACCEPT ASSIGNMENT? For open claims, see back <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1230.45	29. AMOUNT PAID \$ 0.00	30. Resvd 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 hereof.) ADA County Paramedics 04 20 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH# ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK (LUNG) <input checked="" type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 751D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) RODGERS DANIEL E						3. PATIENT'S BIRTH DATE MM DD YY 1949 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) RODGERS DANIEL E														
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd														
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE			CITY Kuna			STATE ID											
ZIP CODE 83634			TELEPHONE (Include Area Code) ( )						ZIP CODE 83634			TELEPHONE (Include Area Code) ( )											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) RODGERS DANIEL E						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER 75						b. AUTO ACCIDENT? PLACE (State)						a. INSURED'S DATE OF BIRTH MM DD YY 1949 M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
d. RESERVED FOR NUCC USE						c. OTHER ACCIDENT?						b. OTHER CLAIM ID (Designated by NUCC)											
e. RESERVED FOR NUCC USE						10d. CLAIM CODES (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon											
d. INSURANCE PLAN NAME OR PROGRAM NAME Centurion of ID IDOC						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
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 2021				SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 15 2021 QUAL 431						15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES						22. RESUBMISSION CODE ORIGINAL REF. NO.											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. R509 B. C. D. E. F. G. H. I. J. K. L. ICD Ind. 0						23. PRIOR AUTHORIZATION NUMBER 83634						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. ERSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #											
1. 04152021 04152021 41 Y A0427 EH A 978 15 1 NPI						2. 04152021 04152021 41 Y A0425 EH A 189 02 13.2 NPI						3. NPI											
4. NPI						5. NPI						6. NPI											
25. FEDERAL TAX I.D. NUMBER 0277				SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 258A				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1167.17		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics 04 20 2023						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 190 E Bannock Street Boise, ID 83712-6241						33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987											

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





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**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 21ID							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patrick Richard W						3. PATIENT'S BIRTH DATE MM DD YY 1939 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634-1350 TELEPHONE (Include Area Code): (208) 386-9588						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195									
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State):						b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 8, 9a, and 9d.									
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 16 2021												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 04 16 2021 QUAL 431						15. OTHER DATE QUAL 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. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. I079 B. C. D. E. F. G. H. I. J. K. L. ICD Ind: 0												22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER 83634					
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. EPSTI Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 04162021 04162021		41		Y		AMBULANCE SERVICE - ALS1 A0427 EH A				978 15		1				NPI					
2 04162021 04162021		41		Y		MILEAGE A0425 EH A				196 18		13.7				NPI					
3																NPI					
4																NPI					
5																NPI					
6																NPI					
25. FEDERAL TAX I.D. NUMBER 0277						26. PATIENT'S ACCOUNT NO. 422A						27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
28. TOTAL CHARGE \$ 1174.33						29. AMOUNT PAID \$ 0.00						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.) ADA County Paramedics 04 20 2023						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK/LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SAUNDER CLIFFORD D						3. PATIENT'S BIRTH DATE MM DD YY 01 19 1973	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAUNDER CLIFFORD D
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:	7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10d. CLAIM CODES (Designated by NUCC)	11. INSURED'S DATE OF BIRTH MM DD YY 01 19 1973
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 04-19-2021						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	11. INSURED'S DATE OF BIRTH MM DD YY 01 19 1973
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 19 2021			15. OTHER DATE QUAL 431			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. R569 B. C. D. E. F. G. H. I. J. K. L.						22. RESUBMISSION CODE	23. PRIOR AUTHORIZATION NUMBER 83634
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
04192021 04192021		41	Y	A0427 EH		A	1054 53
04192021 04192021		41	Y	A0425 EH		A	189 02 13.2
25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 773A		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 1243 55	29. AMOUNT PAID \$ 0 00
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.) ADA County Paramedics 04 20 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) B2 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V				3. PATIENT'S BIRTH DATE MM DD YY 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V													
5. PATIENT'S ADDRESS (No., Street) PO Box 51 CITY STATE ID Boise ID				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) PO Box 51 CITY STATE ID Boise ID													
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER b. INSURED'S DATE OF BIRTH MM DD YY 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>													
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 19 2021		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 04 19 2021 QUAL 431		15. OTHER DATE QUAL MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R079 B. C. D. E. F. G. H. I. J. K. L. ICD Ind. 0				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 19 2021 04 19 2021		B. PLACE OF SERVICE 41		C. EMG Y		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER A0427 SH A		E. DIAGNOSIS POINTER A		F. \$ CHARGES 1140 47		G. DAYS OR UNITS 1		H. EPSDT (Family Plan) NPI		I. ID. QUAL NPI		J. RENDERING PROVIDER ID.#	
25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 796A		27. ACCEPT ASSIGNMENT? (For gov. claims see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1328 06		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 20 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987											

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 57ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Narvaiz Monica L						3. PATIENT'S BIRTH DATE MM DD YY 1984 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Narvaiz Monica L														
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd											
CITY Kuna			STATE ID			CITY Kuna			STATE ID			CITY Kuna			STATE ID								
ZIP CODE 83634			TELEPHONE (Include Area Code) (208) 219-3911			ZIP CODE 83634			TELEPHONE (Include Area Code) (208) 219-3911			ZIP CODE 83634			TELEPHONE (Include Area Code) (208) 219-3911								
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY 1984 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.											
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 19 2021												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 04 19 2021 QUAL 431						15. OTHER DATE QUAL 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. <input type="checkbox"/>						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
17b. NPI						17c. <input type="checkbox"/>						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												22. RESUBMISSION CODE ORIGINAL REF. NO.											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: 0												23. PRIOR AUTHORIZATION NUMBER 83634-0000											
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSTD Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																							
1 04192021 04192021 41 Y A0429 EH A 660.94 1 NPI																							
2 04192021 04192021 41 Y A0425 EH A 194.75 13.6 NPI																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER 0277						26. PATIENT'S ACCOUNT NO. 858A						27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
28. TOTAL CHARGE \$ 855.69						29. AMOUNT PAID \$ 0.00						30. Rev'd 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.) ADA County Paramedics 04 20 2023												32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION  
CARRIER





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 10 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SIMON BRENT										3. PATIENT'S BIRTH DATE MM DD YY 1950 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SIMON BRENT										7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID									
8. RESERVED FOR NUCC USE										8. RESERVED FOR NUCC USE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY 1950 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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 19 2021										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 04 19 2021 QUAL 431										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. I R0602 B. C. D. E. F. G. H. I. J. K. L.										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										22. RESUBMISSION CODE ORIGINAL REF. NO.									
B. PLACE OF SERVICE										23. PRIOR AUTHORIZATION NUMBER 83634									
C. EMG										24. D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HPCS MODIFIER									
E. DIAGNOSIS POINTER										F. \$ CHARGES									
G. DAYS OR UNITS										H. EPSS Family Plan									
I. ID. QUAL										J. RENDERING PROVIDER ID. #									
1. 04192021 04192021 41 Y A0427 EH A 1205 18 1 NPI										AMBULANCE SERVICE - ALS1									
2. 04192021 04192021 41 Y A0425 EH A 189 02 13.2 NPI										MILEAGE									
3. NPI																			
4. NPI																			
5. NPI																			
6. NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 862A									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1394 20									
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
DATE 04 20 2023										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									
SIGNED DATE										9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 42ID	
2. PATIENT'S NAME (Last Name; First Name, Middle Initial) Dade Dana J						3. PATIENT'S BIRTH DATE MM DD YY 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name; First Name, Middle Initial) TSCY DAHO						
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna ID: 83634						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL CITY: Boise ID: 83707						
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon						
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>						

**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 04 20 2021 QUAL: 431				15. OTHER DATE QUAL: _____ 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. _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
17b. NPI				19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I000 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____				ICD ind: 0				22. RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER 83634											

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPIC Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
04202021 04202021	41	Y	A0427 EH	A	1042.86	1		NPI	
04202021 04202021	41	Y	A0425 EH	A	196.18	13.7		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 927A		27. ACCEPT ASSIGNMENT? (For govt. claims see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1239.04		29. AMOUNT PAID \$ 0.00		30. Rev'd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (It certifies that the statements on the reverse apply to this bill and are made a part thereof.) ADA County Paramedics 04 20 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA																													
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 57ID																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Narvaiz Monica L										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Narvaiz Monica L																													
3. PATIENT'S BIRTH DATE (MM DD YY) 1984 M <input type="checkbox"/> F <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd																													
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																													
CITY Kuna					STATE ID					CITY Kuna					STATE ID																								
ZIP CODE 83634					TELEPHONE (Include Area Code) (208) 219-3911					ZIP CODE 83634					TELEPHONE (Include Area Code) (208) 219-3911																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH (MM DD YY) 1984 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					SEX																								
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)																													
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																													
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 04-20-2021																				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) 04 20 2021 QUAL 431										15. OTHER DATE (MM DD YY)										18. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 83634-0000																			
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																							
1 AMBULANCE SERVICE - BLS 04202021 04202021 41 Y A0429 EH A 660 94 1 NPI																																							
2 MILEAGE 04202021 04202021 41 Y A0425 EH A 194 75 13.6 NPI																																							
3 NPI																																							
4 NPI																																							
5 NPI																																							
6 NPI																																							
25. FEDERAL TAX I.D. NUMBER 0277					SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 998A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 855 69					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																			
SIGNED					DATE 04 20 2023					a. 9987					b.																								

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input checked="" type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 78 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>BRONCHO MONNIE</b>						3. PATIENT'S BIRTH DATE ███-██-██ 1970 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>BRONCHO MONNIE</b>														
5. PATIENT'S ADDRESS (No., Street) <b>13900 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) <b>13900 S Pleasant Valley Rd</b>														
CITY <b>Kuna</b>		STATE <b>ID</b>		8. RESERVED FOR NUCC USE		CITY <b>Kuna</b>		STATE <b>ID</b>		ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>( )</b>		ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>( )</b>							
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH ██-██-██ 1970 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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.  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 04 21 2021 QUAL 431						15. OTHER DATE QUAL 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. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
17b. NPI						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. <b>T50904A</b> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____												22. RESUBMISSION CODE ORIGINAL REF. NO.						23. PRIOR AUTHORIZATION NUMBER <b>83634-0000</b>					
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. EPBDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #					
1 04212021 04212021		41		Y		A0427 EH		A		1205 18		1		NPI									
2 04212021 04212021		41		Y		A0425 EH		A		196 18		13.7		NPI									
3														NPI									
4														NPI									
5														NPI									
6														NPI									
25. FEDERAL TAX I.D. NUMBER <b>0277</b>						26. PATIENT'S ACCOUNT NO. <b>141A</b>						27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
28. TOTAL CHARGE <b>\$ 1401 36</b>						29. AMOUNT PAID <b>\$ 0 00</b>						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.) <b>ADA County Paramedics</b>						32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>						33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>9987</b>											
SIGNED _____ DATE <b>04 20 2023</b>																							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 49 ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) KELLY KEVIN H	3. PATIENT'S BIRTH DATE MM DD YY 1964 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
4. INSURED'S NAME (Last Name, First Name, Middle Initial) KELLY KEVIN H	5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )
8. RESERVED FOR NUCC USE	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
b. RESERVED FOR NUCC USE	11. INSURED'S DATE OF BIRTH MM DD YY 1964 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
c. RESERVED FOR NUCC USE	b. OTHER CLAIM ID (Designated by NUCC)
d. INSURANCE PLAN NAME OR PROGRAM NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon
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 _____	10d. CLAIM CODES (Designated by NUCC)
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 21 2021 QUAL: 431	15. OTHER DATE QUAL: 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind: 0 A: R109 B: _____ C: _____ D: _____ E: _____ F: _____ G: _____ H: _____ I: _____ J: _____ K: _____ L: _____
22. RESUBMISSION CODE ORIGINAL REF. NO.:	23. PRIOR AUTHORIZATION NUMBER 83634
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/Facility Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/> 0277 26. PATIENT'S ACCOUNT NO. 152A 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28. TOTAL CHARGE \$ 1336.65 29. AMOUNT PAID \$ 0.00 30. Flsrd for NUCC Use
1. AMBULANCE SERVICE - ALS1 04212021 04212021 41 Y A0427 EH A 1140.47 1 NPI	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.) ADA County Paramedics 04 20 2023
2. MILEAGE 04212021 04212021 41 Y A0425 EH A 196.18 13.7 NPI	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309
3. _____ NPI	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
4. _____ NPI	SIGNED _____ DATE _____
5. _____ NPI	9987
6. _____ NPI	9987

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>											
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 28ID							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hunsaker Richard				3. PATIENT'S BIRTH DATE MM DD YY 1965 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCT IDAHO					
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL CITY: Boise STATE: ID					
8. RESERVED FOR NUCC USE				8. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street) CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. (also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: SIGNATURE ON FILE DATE: 04 22 2023											
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 04 22 2021 QUAL: 431				15. OTHER 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. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0				22. RESUBMISSION CODE ORIGINAL REF. NO.							
A. R4182 B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER 83634							
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/Facility Plan I. ID. QUAL J. RENDERING PROVIDER ID. #											
1. 04222021 04222021 41 Y A0427 EH A 1119.24 1 NPI											
2. 04222021 04222021 41 Y A0425 EH A 196.18 13.7 NPI											
3. NPI											
4. NPI											
5. NPI											
6. NPI											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 229A		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1315.42		29. AMOUNT PAID \$ 0.00	
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.) ADA County Paramedics 04 20 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498			

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 95ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) WILLIAMS KILBY D										3. PATIENT'S BIRTH DATE (MM/DD/YY) 1984 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) WILLIAMS KILBY D										5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
CITY Kuna					STATE ID					CITY Kuna					STATE ID				
ZIP CODE 83634					TELEPHONE (Include Area Code) (208) 680-2873					ZIP CODE 83634					TELEPHONE (Include Area Code) (208) 680-2873				
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 checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH (MM/DD/YY) 1984 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX					b. OTHER CLAIM ID (Designated by NUCC)				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					10d. CLAIM CODES (Designated by NUCC)					11. INSURED'S POLICY GROUP OR FECA NUMBER				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					11. INSURED'S POLICY GROUP OR FECA NUMBER					12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.				
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 23 2021										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) 04/23/2021 QUAL 431										15. OTHER DATE (MM/DD/YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM TO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Mod: 0 A. G8911 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER 83634										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1. 04232021 04232021 41 Y A0427 EH A 1054 53 1 NPI										AMBULANCE SERVICE - ALS1									
2. 04232021 04232021 41 Y A0425 EH A 196 18 13.7 NPI										MILEAGE									
3. NPI																			
4. NPI																			
5. NPI																			
6. NPI																			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 362A									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1250 71									
29. AMOUNT PAID \$ 0 00										30. Rcvd 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498										9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDIKAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>81 ID</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Ridgley Lee A</b>						3. PATIENT'S BIRTH DATE <b>1954</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TCC ID CorrecCenter</b>															
5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b>											
CITY <b>Kuna</b>				STATE		8. RESERVED FOR NUCC USE				CITY <b>Boise</b>				STATE									
ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>(208) 331-1195</b>				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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/> )											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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. SIGNED: <b>SIGNATURE ON FILE</b> DATE: <b>04 24 2021</b>												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: <b>SIGNATURE ON FILE</b>											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>04 24 2021</b> QUAL <b>431</b>						15. OTHER DATE QUAL 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. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind. <b>0</b>												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. <b>R0602</b>						B. _____						C. _____						D. _____					
E. _____						F. _____						G. _____						H. _____					
I. _____						J. _____						K. _____						L. _____					
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/HPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS CR UNITS		H. EPOSD Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #			
1 <b>04242021 04242021</b>		<b>41</b>		<b>Y</b>		<b>A0427 EH</b>				<b>A</b>		<b>1140 47</b>		<b>1</b>		<b>NPI</b>		<b></b>					
2 <b>04242021 04242021</b>		<b>41</b>		<b>Y</b>		<b>A0425 EH</b>				<b>A</b>		<b>189 02</b>		<b>13 2</b>		<b>NPI</b>		<b></b>					
3																<b>NPI</b>							
4																<b>NPI</b>							
5																<b>NPI</b>							
6																<b>NPI</b>							
25. FEDERAL TAX I.D. NUMBER <b>0277</b>				SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>517A</b>				27. ACCEPT ASSIGNMENT? (For opt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ <b>1329 49</b>		29. AMOUNT PAID \$ <b>0 00</b>		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.) <b>ADA County Paramedics</b>						32. SERVICE-FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>						33. BILLING PROVIDER INFO & PH# <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b>											
SIGNED: _____ DATE: <b>04 20 2023</b>						SIGNED: _____ DATE: <b>04 20 2023</b>						SIGNED: _____ DATE: <b>04 20 2023</b>											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA	PICA											
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA <input type="checkbox"/> (ID#)	FLK/LUNG <input checked="" type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (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		SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Shields Keith L							MM DD YY 1974		M <input checked="" type="checkbox"/> F <input type="checkbox"/>	ISCT IDAHO		
5. PATIENT'S ADDRESS (No., Street)							6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)			
13500 S Pleasant Valley Rd							Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		ATTN MEDICAL			
CITY			STATE	8. RESERVED FOR NUCC USE				CITY			STATE	
Kuna			ID					Boise			ID	
ZIP CODE		TELEPHONE (Include Area Code)					ZIP CODE		TELEPHONE (Include Area Code)			
83634-0000		(208) 861-7718					83707		(208) 331-1195			
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			
Shields Keith L									1607			
a. OTHER INSURED'S POLICY OR GROUP NUMBER							a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH		SEX	
6000							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY 1967		M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE							b. AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated by NUCC)			
							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME			
							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Corizon			
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
PacificSource Medicare									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO // yes, complete items 9, 9a, and 9d.			
12. PATIENT'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						DATE 12 19 2013						
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)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
MM DD YY 04 25 2021				QUAL 431				FROM TO MM DD YY MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE							17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
									FROM TO MM DD YY MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? \$ CHARGES					
							<input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)							22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. I0603							0					
B. _____							23. PRIOR AUTHORIZATION NUMBER					
C. _____							83634					
D. _____												
E. _____												
F. _____												
G. _____												
H. _____												
I. _____												
J. _____												
K. _____												
L. _____												
24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON (Only Pat)	I. ID. QUAL	J. RENDERING PROVIDER ID. #			
From To MM DD YY MM DD YY			(Explain Unusual Circumstances) CPT/HCPCS MODIFIER	POINTER								
1	04252021	04252021	41	Y	A0427	EH	A	1209	72	1	NPI	
2	04252021	04252021	41	Y	A0425	EH	A	189	02	13.2	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?		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use
0277		<input type="checkbox"/> X		652A		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 1398 74		\$ 0 00		
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 #				
ADA County Paramedics				FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634				ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498				
04 20 2023				TO: 1055 N Curtis Road				Boise ID 83704-8498				
SIGNED				DATE				Boise, ID 83704-1309				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 42 ID		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhodes, Billy G					3. PATIENT'S BIRTH DATE MM DD YY 1973 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO				
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL				
CITY Kuna		STATE ID		8. RESERVED FOR NUCC USE			CITY Boise		STATE ID			
ZIP CODE 83634		TELEPHONE (Include Area Code) (208) 331-2760			ZIP CODE 83707		TELEPHONE (Include Area Code) (208) 331-1195					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
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 _____		SIGNED _____					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 26 2021 QUAL 431					15. OTHER DATE QUAL 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. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					17b. (NP) _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.		
A. R509		B. _____		C. _____		D. _____		E. _____		23. PRIOR AUTHORIZATION NUMBER 83634		
E. _____		F. _____		G. _____		H. _____		I. _____		24. A. DATE(S) OF SERVICE		
I. _____		J. _____		K. _____		L. _____		F. \$ CHARGES		G. DAYS OF UNITS		
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		H. EPSDT (Family Plan)		
1 04262021 04262021 41 Y		41 Y		A0427 EH A		1042 86 1		NPI		J. RENDERING PROVIDER ID. #		
2 04262021 04262021 41 Y		41 Y		A0425 EH A		194 75 13 6		NPI		NPI		
3		4		5		6		NPI		NPI		
5		6		NPI		NPI		NPI		NPI		
6		NPI		NPI		NPI		NPI		NPI		
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		
0277		[X]		723A		YES [X] NO		\$ 1237.61		\$ 0.00		
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.) ADA County Paramedics					32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309			33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498				
SIGNED		DATE		Boise, ID 83704-1309		9987		a		b		



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA		PICA	
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 8845	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Flores Ramirez Juan M		4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter	
3. PATIENT'S BIRTH DATE (MM DD YY) 1977 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX		7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL	
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Road		8. RESERVED FOR NUCC USE	
CITY: Kuna STATE: ID		CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 875-7052		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760	
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 checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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 29 2021		11. INSURED'S POLICY GROUP OR FECA NUMBER 1607	
		a. INSURED'S DATE OF BIRTH (MM DD YY) M <input type="checkbox"/> F <input type="checkbox"/> SEX	
		b. OTHER CLAIM ID (Designated by NUCC)	
		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
		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) 04 29 2021 QUAL 431		15. OTHER DATE (MM DD YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. H538 ICD Ind. 0		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE C. SERVICE EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9/Family Plan ID. I. QUAL J. RENDERING PROVIDER ID. #		22. RESUBMISSION CODE ORIGINAL REF. NO.	
1. 04292021 04292021 41 Y A0429 EH A 660 94 1 NPI		23. PRIOR AUTHORIZATION NUMBER 83634	
2. 04292021 04292021 41 Y A0425 EH A 189 02 13.2 NPI			
3. NPI			
4. NPI			
5. NPI			
6. NPI			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 128A	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 849 96	
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 20 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	
33. BILLING PROVIDER INFO & PH # (208) 287 2950		ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE (Medicare#) <input type="checkbox"/>		MEDICAID (Medicaid#) <input type="checkbox"/>		TRICARE (ID#/DoD#) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (ID#) <input type="checkbox"/>		FECA BLK LUNG (ID#) <input type="checkbox"/>		OTHER (ID#) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 04ID					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MOORE BENNIE J						3. PATIENT'S BIRTH DATE MM DD YY 1974 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) MOORE BENNIE J										
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID										
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY 1974 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY 1974 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER					
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 05 05 2021		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 05 05 2021 QUAL 431		15. OTHER DATE QUAL 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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. I R531 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER 83634		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. EXIST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER 0277		26. PATIENT'S ACCOUNT NO. 947A		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1394.20		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics 04 20 2023						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987							

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA	PICA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 32 ID											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V					3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V				
5. PATIENT'S ADDRESS (No., Street) PO Box 51					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) PO Box 51				
CITY Boise		STATE ID		8. RESERVED FOR NUCC USE			CITY Boise		STATE ID			
ZIP CODE 83707		TELEPHONE (Include Area Code) (208) 233-6909						ZIP CODE 83707		TELEPHONE (Include Area Code) (208) 233-6909		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED] 5141								a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE								b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE								c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon				
d. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA HEALTH CARE					10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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. SIGNED SIGNATURE ON FILE DATE 05-09-2021										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 05 09 2021 QUAL 431					15. OTHER DATE QUAL 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. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service time below (24E) ICD Ind. 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.								22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634				
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. EPSTU Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1 05092021 05092021		41	Y	A0427 SH		A	1140 47	1	NPI			
2 05092021 05092021		41	Y	A0425 SH		A	187 59	13.1	NPI			
3									NPI			
4									NPI			
5									NPI			
6									NPI			
25. FEDERAL TAX I.D. NUMBER [REDACTED] 0277		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. [REDACTED] 477A		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1328 06		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 20 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [REDACTED] 9987				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>53 ID</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Snider Mack L</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SICI</b>	
3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX <b>1961 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTEN VAUGHN</b>	
5. PATIENT'S ADDRESS (No., Street) <b>13950 S Pleasant Valley Rd</b>		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY: <b>Kuna</b> STATE: <b>ID</b>		CITY: <b>Boise</b> STATE: <b>ID</b>	
ZIP CODE: <b>83634</b> TELEPHONE (Include Area Code): <b>(208) 836-1260</b>		ZIP CODE: <b>83707</b> TELEPHONE (Include Area Code): <b>(208) 333-0037</b>	
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 checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
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: <b>SIGNATURE ON FILE</b> DATE: <b>05-10-2021</b>		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: <b>SIGNATURE ON FILE</b>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) QUAL <b>05/10/2021 QUAL 431</b>		15. OTHER DATE (MM/DD/YY) QUAL 17a. <input type="checkbox"/> 17b. NPI	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind: <b>0</b>		22. RESUBMISSION CODE ORIGINAL REF NO:	
A. <b>I4891</b> B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER <b>83634-0000</b>	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1. <b>05102021 05102021 41 Y A0427 EH A 1140.47 1 NPI</b>			
2. <b>05102021 05102021 41 Y A0425 EH A 196.18 13.7 NPI</b>			
3. NPI			
4. NPI			
5. NPI			
6. NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>618A</b>	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>1336.65</b>	
29. AMOUNT PAID \$ <b>0.00</b>		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.) <b>ADA County Paramedics</b> DATE: <b>04 20 2023</b>		32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>	
33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b>		33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498</b>	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 12ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Roman John W		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Alt Placement Correctional	
5. PATIENT'S ADDRESS (No., Street) 1050 N Clover Dr CITY: Boise STATE: ID ZIP CODE: 83703 TELEPHONE (Include Area Code): (208) 985-5522		7. INSURED'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Roman John W		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 0029		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
d. INSURANCE PLAN NAME OR PROGRAM NAME IDHW		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
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 05 10 2021		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 05 10 2021 QUAL 431		15. OTHER DATE MM DD YY QUAL 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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. R112 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634	
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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1. AMBULANCE SERVICE - ALS1 05102021 05102021 41 Y A0427 SH A 983 45 1 NPI			
2. MILEAGE 05102021 05102021 41 Y A0425 SH A 193 32 13.5 NPI			
3. NPI			
4. NPI			
5. NPI			
6. NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 645A	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1176 77	
29. AMOUNT PAID \$ 0 00		30. Rsv'd 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.) ADA County Paramedics 04 20 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	
33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498		9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 201D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ANDERSON RIO J										3. PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input checked="" type="checkbox"/> ██████████ 1997 M									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ANDERSON RIO J										5. PATIENT'S ADDRESS (No., Street) 2366 E Old Penitentiary Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 2366 E Old Penitentiary Rd									
CITY Boise					STATE ID					CITY Boise					STATE ID				
ZIP CODE 83712					TELEPHONE (Include Area Code) (208) 900-8629					ZIP CODE 83712					TELEPHONE (Include Area Code) (208) 900-8629				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input checked="" type="checkbox"/> ██████████ 1997 M									
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 05 11 2021										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 05 11 2021 QUAL 431										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. I R55 B. C. D. ICD Ind. 0 E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER 83712									
1. 05112021 05112021 41 Y A0427 SH A 1140.47 1 NPI										AMBULANCE SERVICE - ALS1									
2. 05112021 05112021 41 Y A0425 SH A 25.78 1.8 NPI										MILEAGE									
3. NPI																			
4. NPI																			
5. NPI																			
6. NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28. TOTAL CHARGE \$ 1166.25 29. AMOUNT PAID \$ 0.00 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.) ADA County Paramedics 04 20 2023									
32. SERVICE FACILITY LOCATION INFORMATION FROM: 2366 E Old Penitentiary Rd Boise, ID 83712 TO: 190 E Bannock Street Boise, ID 83712-6241										33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 ██████████ 9987									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA/BLK LUNG <input type="checkbox"/> (ID#)            OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 42 ID																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Pena Jose A					3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] 1986 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) TRCT IDAHO																			
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL																			
CITY Kuna			STATE ID		8. RESERVED FOR NUCC USE			CITY Boise			STATE ID																		
ZIP CODE 83634			TELEPHONE (Include Area Code) (208) 386-9588		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED] 1607																		
b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			b. OTHER CLAIM ID (Designated by NUCC)																		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																		
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.		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 DATE 05 12 2021										SIGNED SIGNATURE ON FILE		SIGNED SIGNATURE ON FILE																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 05 12 2021 QUAL 431					15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					22. RESUBMISSION CODE ORIGINAL REF. NO.														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0										A. R002					23. PRIOR AUTHORIZATION NUMBER B3634														
24. A. DATE(S) OF SERVICE From To MM DD YY 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. EPSTD Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #										
1		05122021 05122021		41 Y		AMBULANCE SERVICE - ALS1			A		1140 47		1		NPI														
2		05122021 05122021		41 Y		MILEAGE			A		189 02		13.2		NPI														
3															NPI														
4															NPI														
5															NPI														
6															NPI														
25. FEDERAL TAX I.D. NUMBER    SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO.    954A					27. ACCEPT ASSIGNMENT? (For Govt. Claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 1329 49					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									
SIGNED DATE 04 20 2023										SIGNED DATE [REDACTED] 9987										SIGNED DATE [REDACTED] 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA  PICA

<input type="checkbox"/> MEDICARE <input type="checkbox"/> (Medicare#)		<input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#)		<input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DoD#)		<input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#)		<input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		<input type="checkbox"/> FECA <input type="checkbox"/> (ID#)		<input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 411D													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BEVERLY JON L				3. PATIENT'S BIRTH DATE MM DD YY 1987 M X F				4. INSURED'S NAME (Last Name, First Name, Middle Initial) BEVERLY JON L				7. INSURED'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd															
5. PATIENT'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				8. RESERVED FOR NUCC USE				11. INSURED'S POLICY GROUP OR FECA NUMBER															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S DATE OF BIRTH MM DD YY 1987 M X F				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.															
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)															
b. RESERVED FOR NUCC USE				c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon															
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.															
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												SIGNED SIGNATURE ON FILE DATE 05 13 2021				SIGNED SIGNATURE ON FILE											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 13 2021 QUAL 431				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER 83634											
A. M79605		B.		C.		D.		E.		F.		G.		H.		I.		J.									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE EMG		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPBDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID.#									
1		05132021		05132021		41 Y		A0429 SH A		660 94		1		NPI													
2		05132021		05132021		41 Y		A0425 SH A		196 18		13.7		NPI													
3														NPI													
4														NPI													
5														NPI													
6														NPI													
25. FEDERAL TAX I.D. NUMBER 0277				SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 053A				27. ACCEPT ASSIGNMENT? (For gov. billing, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 857 12				29. AMOUNT PAID \$ 0 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.) ADA County Paramedics								32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309								33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498											
SIGNED DATE 04 20 2023				SIGNED DATE 09987																							

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Storey Gregory S						3. PATIENT'S BIRTH DATE MM DD YY 1949 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO				
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL				
CITY Boise			STATE ID	8. RESERVED FOR NUCC USE				CITY Boise	STATE ID		
ZIP CODE 83705		TELEPHONE (Include Area Code) (208) 331-1195				ZIP CODE 83707		TELEPHONE (Include Area Code) (208) 331-1195			
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)			a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?			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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.					
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 05 13 2021						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 05 13 2021 QUAL 431			15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind. 0						22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. I499	B.	C.	D.	E.	F.	G.	H.	I.			
E.	F.	G.	H.	I.	J.	K.	L.	M.			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #						23. PRIOR AUTHORIZATION NUMBER					
1	05132021	05132021	41	Y	A0433	EH	A	1177 60	1	NPI	83634
2	05132021	05132021	41	Y	A0425	EH	A	196 18	13.7	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 142A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1373 78	29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 20 2023			32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309			33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Carson Tara</b>		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX <b>1991 M</b> <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>PRISON DOC WOMENS</b>		5. PATIENT'S ADDRESS (No., Street) <b>13200 S Pleasant Valley Rd</b>	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTEN LARRY HEINZ</b>	
8. RESERVED FOR NUCC USE		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX <b>Boise</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
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. <b>SIGNED SIGNATURE ON FILE</b> DATE <b>05 14 2021</b>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>SIGNED SIGNATURE ON FILE</b>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) QUAL <b>05 14 2021 QUAL 431</b>		15. OTHER DATE (MM/DD/YY) QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) (MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD ind: <b>0</b>		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. <b>R509</b> B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER <b>83634-2720</b>	
24. A. DATE(S) OF SERVICE From To 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. #		24. A. DATE(S) OF SERVICE From To 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. <b>05142021 05142021 41 Y A0427 EH A 978 15 1 NPI</b>		1. <b>05142021 05142021 41 Y A0427 EH A 978 15 1 NPI</b>	
2. <b>05142021 05142021 41 Y A0425 EH A 177 57 12.4 NPI</b>		2. <b>05142021 05142021 41 Y A0425 EH A 177 57 12.4 NPI</b>	
3. NPI		3. NPI	
4. NPI		4. NPI	
5. NPI		5. NPI	
6. NPI		6. NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
<b>0277</b> <input type="checkbox"/> <input checked="" type="checkbox"/>		<b>271A</b>	
28. TOTAL CHARGE \$ <b>1155 72</b>		29. AMOUNT PAID \$ <b>0 00</b>	
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.) <b>ADA County Paramedics</b> DATE <b>04 20 2023</b>	
32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13200 S Pleasant Valley Rd Kuna, ID 83634-2720</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>		33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE 973 MM DD

4. INSURED'S NAME (Last Name, First Name, Middle Initial) 421D

5. PATIENT'S ADDRESS (No. Street) 13500 S Pleasant Valle Rd

6. PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street) ATTN MEDICAL

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO: 83707

11. INSURED'S POLICY GROUP OR FECA NUMBER (208) 331-1195

12. INSURED'S DATE OF BIRTH 1967 MM DD

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? Corizon

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. AUTO ACCIDENT? YES NO

16. OTHER ACCIDENT? YES NO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 05 15 2021

20. DATE OF SIGNATURE ON FILE

21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.

22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-I to service line below (24E) ICD Ind: 0

24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NN. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

25. FEDERAL TAX ID NUMBER 0277

26. PATIENT'S ACCOUNT NO. 356A

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE 1401.36

29. AMOUNT PAID 0.00

30. Resvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # (208) 287 2950

370 N. Benjamin Lane

Boise, ID 837 4-1309

DATE 04 20 2023

SIGNED O: 1 N

Boise, ID 83634

FROM: 13500 S PLEASANT VALLEY RD ADA COUNTY PARAMEDICS

ADA County Paramedics

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)

2. PATIENT'S NAME (Last Name; First Name, Middle Initial) OVERBEEK APRIL
3. PATIENT'S BIRTH DATE (MM DD YY) 986 M F
4. INSURED'S NAME (Last Name; First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 13200 S Pleasant Valle Rd
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street) ATTEN LARRY HEINZ

CITY Kuna ID
STATE ID
8. RESERVED FOR NUCC USE
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)
a. INSURED'S DATE OF BIRTH (MM DD YY) M F

b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? (YES NO) PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) If yes, complete items 9, 9a, and 9d.

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 SIGNATURE ON FILE DATE
SIGNED SI

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 05 16 2021 QUAL 431
15. OTHER DATE (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? (YES NO) \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind. 0
A. R0789 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER 83634-2720

24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. G. DAYS OR UNITS H. I. ID. J. RENDERING PROVIDER ID. #
From To PLACE OF SERVICE EMG OPT/HCPCS MODIFIER DIAGNOSIS POINTER \$ CHARGES

1 05162 21 05162021 41 Y A0429 EH A 725 65 1 NPI
AMBULANCE SERVICE - BLS

2 05162 21 05162021 41 Y A0425 EH A 177 57 12.4 NPI
MILEAGE

3 NPI
4 NPI
5 NPI
6 NPI

25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN
26. PATIENT'S ACCOUNT NO. 534A
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE \$ 903 22 \$ 0 0
29. AMOUNT PAID
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 LOCATIO INFORMATION
33. BILLING PROVIDER INFO & PH # (208)287 2950

ADA County Paramedics FROM: 13200 S Pleasant Valley Rd ADA COUNTY PARAMEDICS
Kuna, ID 83634-2720 370 N. Benjamin Lane
Boise ID 7 4-
Boise, ID 837 4-1309 9987

SIGNED DATE 04 20 2023 T 1 is Road
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

Corizon
PO Box 981639
El Paso, TX 79998

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

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLX/LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. RESERVED FOR NUCC USE
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
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
15. OTHER DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to services line below (24E)
22. RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER

Table with 10 columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL, J. REFERRING PROVIDER ID. #

24. FEDERAL TAX I.D. NUMBER
25. SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH#



Corizon  
PO Box 981639  
El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA BLK (LUNG)  OTHER  1a. INSURED ID NUMBER (For Program in Item 1) **82ID**  
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)  
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **HOLLAND TRAVIS E**  
3. PATIENT'S BIRTH DATE MM DD YY **0978** SEX  M  F  
4. INSURED'S NAME (Last Name, First Name, Middle Initial) **HOLLAND TRAVIS E**  
5. PATIENT'S ADDRESS (No., Street) **14601 S Pleasant Valle Rd**  
6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other   
7. INSURED'S ADDRESS (No., Street) **14601 S Pleasant Valle Rd**

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE  
**Kuna ID** **Kuna ID**  
ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code)

**83634** **83634**  
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) a. INSURED'S DATE OF BIRTH MM DD YY SEX  
 YES  NO **1978**  M  F  
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)  
 YES  NO  
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT?  YES  NO  
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) 6. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**  
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO If yes, complete items 9, 9a, and 9d.

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  
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY **05 17 2021** QUAL **431** 15. OTHER DATE MM DD YY  
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD ind: **0**  
A. **R50** B. C. D.  
E. F. G. H.  
I. J. K. L.

20. OUTSIDE LAB? \$ CHARGES  YES  NO  
22. RESUBMISSION CODE ORIGINAL REF. NO.  
23. PRIOR AUTHORIZATION NUMBER **83634**

24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. G. H. I. J.  
From To PLACE OF SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS POINTER \$ CHARGES DAYS OR UNITS ERROT Family Plan ID QUAL RENDERING PROVIDER ID.#  
MM DD YY MM DD YY

1. **05172 21 05172 21 41 Y A0427 EH A 1042 6 1 NPI**  
2. **05172 21 05172 21 41 Y A0425 EH A 189 02 13.2 NPI**  
3. NPI  
4. NPI  
5. NPI  
6. NPI

25. FEDERAL TAX I.D. NUMBER **0277** SSN EIN  26. PATIENT'S ACCOUNT NO. **512A** 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO  
28. TOTAL CHARGE \$ **1231 88** 29. AMOUNT PAID \$ **0 0** 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.) **ADA County Paramedics**  
32. SERVICE FACILITY LOCATION INFORMATION **FROM: 13500 S PLEASANT VALLEY RI ADA COUNTY PARAMEDICS Kuna, ID 83634**  
33. BILLING PROVIDER INFO & PH# **370 N. Benjamin Lane 9987 b**

SIGNED **04 20 2023** DATE **Boise, ID 837 4-1309**  
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PATIENT AND INSURED INFORMATION

PICA

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER  1a. INSURED'S I.D. NUMBER (For Program in Item 1) **39ID**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **[REDACTED]** 3. PATIENT'S BIRTH DATE (MM/DD/YY) **[REDACTED]** SEX  M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **ATTN: MEDICAL** 7. INSURED'S ADDRESS (No., Street) **ATTN: MEDICAL**

5. PATIENT'S ADDRESS (No., Street) **13500 S Pleasant Valle Rd** CITY **Kuna** STATE **ID**

6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other  8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **[REDACTED]** 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous)  YES  NO b. AUTO ACCIDENT? (PLACE (State))  YES  NO c. OTHER ACCIDENT?  YES  NO 10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER **83707**

12. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO *If yes, complete items 9, 9a, and 9d.*

13. INSURED'S DATE OF BIRTH (MM/DD/YY) **[REDACTED]** 1967 SEX  M  F

14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. **[REDACTED]**

15. OTHER DATE QUAL **05 18 2021** QUAL **431**

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM **05 18 2021** TO **05 18 2021**

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE **Centurion of ID IDOC**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM **05 18 2021** TO **05 18 2021**

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **[REDACTED]**

20. OUTSIDE LAB?  YES  NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind **0**

A. **R0602** B. **M6281** C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE **83634** ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER **83634**

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

24. A.	DATE(S) OF SERVICE	B.	PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E.	DIAGNOSIS POINTER	F.	\$ CHARGES	G.	DAYS OR UNITS	H.	EPSDT Family Plan	I.	ID. QUAL	J.	RENDERING PROVIDER ID. #
MM	DD	YY	M	DD	YY	EMG	CPT/HCPCS	MODIFIER						NPI			
1	051821	051821	41	Y	A0427	EH	AB							NPI			
2	051821	051821	41	Y	A0425	EH	AB		1961813.7					NPI			
3														NPI			
4														NPI			
5														NPI			
6														NPI			

25. FEDERAL TAX I.D. NUMBER **0277** SSN EIN  26. PATIENT'S ACCOUNT NO. **[REDACTED]** 27. ACCEPT ASSIGNMENT? (For gov. claims, see back)  YES  NO

28. TOTAL CHARGE \$ **1405.90** 29. AMOUNT PAID \$ **0.00** 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.) **ADA County Paramedics**

32. SERVICE FACILITY LOCATION INFORMATION **FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634**

33. BILLING PROVIDER INFO & PH# **ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 704-84 [REDACTED] 9987**

SIGNED **[REDACTED]** DATE **04 20 2023**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION

Corizon  
PO Box 981639  
El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER  1a. INSURED'S I.D. NUMBER (For Program in Item 1) **39ID**  
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Marks Frank** 3. PATIENT'S BIRTH DATE (MM DD YY) **MM DD YY** SEX  M  F  
4. INSURED'S NAME (Last Name, First Name, Middle Initial) **Corizon**  
5. PATIENT'S ADDRESS (No., Street) **14601 S Pleasant Valle Rd** 6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other   
7. INSURED'S ADDRESS (No., Street) **14601 S Pleasant Valle Rd**  
CITY STATE CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code)  
**83634** ( ) **83634** ( )  
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  
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT?  YES  NO PLACE (State) \_\_\_\_\_  
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT?  YES  NO  
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) \_\_\_\_\_  
6. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**  
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO If yes, complete items 9, 9a, and 9d.

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 ~~GNATURE ON FILE~~ DATE SIGNED \_\_\_\_\_  
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE QUAL. MM DD YY MM DD YY  
**05 18 2021** QUAL **431**  
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. 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. **0**  
A. **R079** B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_  
E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_  
I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

22. RESUBMISSION CODE ORIGINAL REF. NO. **83634**  
23. PRIOR AUTHORIZATION NUMBER **83634**

24. A.	DATE(S) OF SERVICE	B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.	F.	G.	H.	I.	J.					
MM	DD	YY	MM	DD	YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL	RENDERING PROVIDER ID. #
1	5	1	05	18	21	41	Y	A0427	H					NPI	
2	05	18	2021	05	18	21	41	Y	A0425	SH	A	242	01	16.9	NPI
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER **0277** SSN EIN   26. PATIENT'S ACCOUNT NO. **309A** 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO  
28. TOTAL CHARGE \$ **1284 87** 29. AMOUNT PAID \$ **0 0** 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.) **ADA County Paramedics**  
32. SERVICE FACILITY LOCATION INFORMATION **FROM: 14601 S PLEASANT VALLEY RI ADA COUNTY PARAMEDICS Kuna, ID 83634**  
33. BILLING PROVIDER INFO & PH # **(208) 287 2950** 370 N. Benjamin Lane

SIGNED \_\_\_\_\_ DATE **Boise ID 837 2-6241** **9987**  
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# HEALTH INSURANCE CLAIM FORM

Corizon  
PO Box 981639  
El Paso, TX 79998

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

CARRIER

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA BLX LUNG  OTHER  1a. INSURED'S I.D. NUMBER (For Program in Item 1) **14ID**

(Medicare#)  (Medicaid#)  (ID#/DoD#)  (Member ID#)  (ID#)  (ID#)

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) **13400 S Pleasant Valle Rd** 6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other

CITY \_\_\_\_\_ STATE \_\_\_\_\_ 7. INSURED'S ADDRESS (No., Street) \_\_\_\_\_

8. RESERVED FOR NUCC USE \_\_\_\_\_ CITY **DI** STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_ TELEPHONE (Include Area Code) \_\_\_\_\_ ZIP CODE \_\_\_\_\_ TELEPHONE (Include Area Code) **(208) 389-0230**

**83634** \_\_\_\_\_ **83707** \_\_\_\_\_

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 b. AUTO ACCIDENT?  YES  NO PLACE (State) \_\_\_\_\_ c. OTHER ACCIDENT?  YES  NO 10d. CLAIM CODES (Designated by NUCC) \_\_\_\_\_

b. RESERVED FOR NUCC USE \_\_\_\_\_ c. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**

c. RESERVED FOR NUCC USE \_\_\_\_\_ d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO *If yes, complete items 9, 9a, and 9d.*

d. INSURANCE PLAN NAME OR PROGRAM NAME \_\_\_\_\_

**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.

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, INJURY, or PREGNANCY (LMP) (MM DD YY) **05 21 2021** QUAL **431** 15. OTHER DATE (MM DD YY) \_\_\_\_\_

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE \_\_\_\_\_ 17a. \_\_\_\_\_ 17b. NPI \_\_\_\_\_

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) \_\_\_\_\_

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. **0**

A. **T1491XA** B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_

E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_

I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

22. RESUBMISSION CODE \_\_\_\_\_ ORIGINAL REF. NO. \_\_\_\_\_

23. PRIOR AUTHORIZATION NUMBER **83634**

24. A.	DATE(S) OF SERVICE	B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.	F.	G.	H.	I.	J.
MM DD YY	From To M DD YY	PLACE OF SERVICE	EM	(Explain Unusual Circumstances) OPT/HCPCS MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL	RENDERING PROVIDER ID. #
1				<b>AMBULANCE SERVICE - ALS1</b>						
2				<b>MILEAGE</b>						
	<b>05212021 05212021</b>	<b>41</b>	<b>Y</b>	<b>A0425 SH</b>		<b>7 59 13.1</b>				
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER \_\_\_\_\_ SSN EIN   \_\_\_\_\_

26. PATIENT'S ACCOUNT NO. \_\_\_\_\_ 27. ACCEPT ASSIGNMENT? (For gov. claims, see back)  YES  NO

28. TOTAL CHARGE \$ **11** 29. AMOUNT PAID \$ **0** 30. Rev'd 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.) **ADA County Paramedics**

32. SERVICE FACILITY LOCATION INFORMATION **FROM: 14601 S PLEASANT VALLEY RD ADA COUNTY PARAMEDICS Kuna, ID 83634**

33. BILLING PROVIDER INFO & PH # **(208) 287 2950**

370 N. Benjamin Lane

PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

Corizon
PO Box 981639
El Paso, TX 79998

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

PICA

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE SEX
4. INSURED'S I.D. NUMBER (For Program in Item 1)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. RESERVED FOR NUCC USE

Boise ID
ZIP CODE TELEPHONE (Include Area Code)
83702 (208) 602-3374
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)
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT?
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
a. INSURED'S DATE OF BIRTH SEX
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME

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.
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
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
15. OTHER DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)
A. I83028A
B.
C.
D.
E.
F.
G.
H.
I.
J.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
83634

Table with 10 columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL, J. RENDERING PROVIDER ID. #

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH #

SIGNED DATE Boise ID 837 4-1309
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input checked="" type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>84 ID</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Ferguson Robert R</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1964 M X F</b>			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ICC ID CorrecCenter</b>											
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b>											
CITY <b>Kuna</b>			STATE <b>ID</b>			8. RESERVED FOR NUCC USE						CITY <b>Boise</b>			STATE <b>ID</b>								
ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>									ZIP CODE <b>83707</b>			TELEPHONE (Include Area Code) <b>(208) 331-2760</b>								
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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.  SIGNED <u>SIGNATURE ON FILE</u> DATE <u>05 26 2021</u>												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 <u>SIGNATURE ON FILE</u>											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>05 26 2021</b> QUAL <b>431</b>						15. OTHER DATE QUAL 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. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: <b>0</b>												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. <b>R079</b> B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER <b>83634</b>											
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) OPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family ICD-9-CM		I. ID. QUAL		J. RENDERING PROVIDER ID. #			
1 <b>05262021 05262021</b>		<b>41</b>		<b>Y</b>		<b>A0427 SH</b>				<b>A</b>		<b>1042 86</b>		<b>1</b>		<b>NPI</b>							
2 <b>05262021 05262021</b>		<b>41</b>		<b>Y</b>		<b>A0425 SH</b>				<b>A</b>		<b>187 59</b>		<b>13.1</b>		<b>NPI</b>							
3																<b>NPI</b>							
4																<b>NPI</b>							
5																<b>NPI</b>							
6																<b>NPI</b>							
25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>845A</b>				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ <b>1230 45</b>				29. AMOUNT PAID \$ <b>0 00</b>				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.) <b>ADA County Paramedics</b> DATE <b>04 20 2023</b>												32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>				33. BILLING PROVIDER INFO & PH# <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>							

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medical#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 631D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CASTORENA CHRISTOPHER G										3. PATIENT'S BIRTH DATE (MM DD YY) 1992 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) CASTORENA CHRISTOPHER G										5. PATIENT'S ADDRESS (No., Street) 15501 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 15501 S Pleasant Valley Rd									
CITY Kuna					STATE ID					CITY Kuna					STATE ID				
ZIP CODE 83634					TELEPHONE (Include Area Code) ( )					ZIP CODE 83634					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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										Corizon									
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: 05 27 2021										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 05 27 2021 QUAL: 431										15. OTHER DATE QUAL: MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below, (24E)) A. I50990XA B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
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 05272021 05272021 41 Y A0429 SH A 660.94 1 NPI										AMBULANCE SERVICE - BLS									
2 05272021 05272021 41 Y A0425 SH A 196.18 13.7 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 964A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 857.12									
29. AMOUNT PAID \$ 0.00										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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH# (208) 287 2950										34. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									
SIGNED: DATE: 04 20 2023										9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)	
TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)	
OTHER <input checked="" type="checkbox"/> (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)	
Passantino Eric B		1962 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)	
ISCI IDAHO		13500 S Pleasant Valley Rd	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		ATTN: MEDICAL	
8. RESERVED FOR NUCC USE		CITY	
		Boise	
STATE		STATE	
ID		ID	
ZIP CODE		ZIP CODE	
83634		83707	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
(208) 877-1062		(208) 331-1195	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
Passantino Eric B		a. EMPLOYMENT? (Current or Previous)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
5906		b. AUTO ACCIDENT? PLACE (State)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
BLUE CROSS			
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH (MM DD YY)	
		1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
a. INSURED'S DATE OF BIRTH (MM DD YY)		SEX	
b. OTHER CLAIM ID (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
c. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
Corizon		SIGNED SIGNATURE ON FILE	
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	
SIGNED SIGNATURE ON FILE		DATE 05 27 2021	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) (MM DD YY) QUAL		15. OTHER DATE (MM DD YY)	
05 27 2021 QUAL 431			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
		17b. NPI	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	
		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ind 0		20. OUTSIDE LAB? \$ CHARGES	
A. R52 B. C. D. E. F. G. H. I. J. K. L.		<input type="checkbox"/> YES <input type="checkbox"/> NO	
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 I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		22. RESUBMISSION CODE ORIGINAL REF. NO.	
1. 05272021 05272021 41 Y A0429 EH A 725 65 1 NPI		23. PRIOR AUTHORIZATION NUMBER	
2. 05272021 05272021 41 Y A0425 EH A 186 16 13 0 NPI		83634	
3. NPI			
4. NPI			
5. NPI			
6. NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
0277 <input checked="" type="checkbox"/> <input type="checkbox"/>		083A	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 911 81	
29. AMOUNT PAID		30. Rsvd for NUCC Use	
\$ 0 00			
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	
ADA County Paramedics		FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	
04 20 2023		TO: 1055 N Curtis Road Boise, ID 83704-1309	
SIGNED DATE		33. BILLING PROVIDER INFO & PH# (208) 287 2950	
		ADA COUNTY PARAMEDICS	
		370 N. Benjamin Lane Boise ID 83704-8498	
		9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	28 ID			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE		SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
Isaak Augustus J				MM/DD/YY 1971		M <input checked="" type="checkbox"/> F <input type="checkbox"/>	TMST Max Security				
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)					
13400 S Pleasant Valley Rd				Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		ATTEN: DIANNA					
CITY		STATE		8. RESERVED FOR NUCC USE		CITY		STATE			
Kuna		ID				Boise		ID			
ZIP CODE		TELEPHONE (Include Area Code)				ZIP CODE		TELEPHONE (Include Area Code)			
83634		(208) 389-0233				83707		(208) 389-0230			
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)		a. INSURED'S DATE OF BIRTH					
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM/DD/YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?		c. OTHER CLAIM ID (Designated by NUCC)					
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME					
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Corizon					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					
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 SIGNATURE ON FILE DATE 05-28-2021						SIGNED SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			15. OTHER DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
MM/DD/YY 05/28/2021 QUAL 431			MM/DD/YY			FROM MM/DD/YY TO MM/DD/YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
			17b. NPI			FROM MM/DD/YY TO MM/DD/YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES					
						<input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)						22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. R531 B. C. D. ICD ICD 0						23. PRIOR AUTHORIZATION NUMBER					
E. F. G. H. I. J. K. L.						83634-2716					
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
From MM/DD/YY To MM/DD/YY		MM/DD/YY	Y	A0427 EH		A	978.15	1	NPI		
1 05/28/2021 05/28/2021		41	Y	AMBULANCE SERVICE - ALS1							
2 05/28/2021 05/28/2021		41	Y	MILEAGE		A	187.59	13.1	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 gov. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use			
0277		<input checked="" type="checkbox"/>	175A		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 1165.74	\$ 0.00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If 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#					
ADA County Paramedics			FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716			ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498					
SIGNED DATE 04 20 2023			TO: 1055 N Curtis Road Boise, ID 83704-1309			a. 9987 b.					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 361D					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Passantino Eric B						3. PATIENT'S BIRTH DATE MM DD YY 1962 M X F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO										
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 377-1062						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Passantino Eric B						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 1967 M X F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO # if yes, complete items 9, 9a, and 9d.							
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 05 29 2021						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 05 28 2021 QUAL 431				15. OTHER DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI		17b. NPI		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. Z889 B. C. D. E. F. G. H. I. J. K. L.						ICD ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER 83634							
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 OF UNITS		H. ICD-9-CM Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 05282021 05282021 41 Y		41		Y		A0427 EH		A		1145 77		1		NPI					
2 05282021 05282021 41 Y		41		Y		A0425 EH		A		196 18		13.7		NPI					
3														NPI					
4														NPI					
5														NPI					
6														NPI					
25. FEDERAL TAX I.D. NUMBER 0277				SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 247A				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1341 95		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 20 2023 SIGNED DATE						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987							



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 64 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Joyce Jourdan										3. PATIENT'S BIRTH DATE (MM/DD/YY) 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Joyce Jourdan										5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
CITY Kuna					STATE ID					CITY Kuna					STATE ID				
ZIP CODE 83634					TELEPHONE (Include Area Code) ( )					ZIP CODE 83634					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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH (MM/DD/YY) 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
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 05-29-2021										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 05/29/2021 QUAL 431										15. OTHER DATE QUAL MM/DD/YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind. 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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. ICD-9-CM Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER 83634									
1 05292021 05292021 41 Y A0427 EH A 978 15 1 NPI										AMBULANCE SERVICE - ALS1									
2 05292021 05292021 41 Y A0425 EH A 196 18 13.7 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> X										26. PATIENT'S ACCOUNT NO. 315A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1174 33									
29. AMOUNT PAID \$ 0 00										30. Rcvd 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.) ADA County Paramedics 04 20 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987																			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA	PICA
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 421D
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Anderson Drew	3. PATIENT'S BIRTH DATE (MM   DD   YY) ████ 1992 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter	5. PATIENT'S ADDRESS (No., Street) 14195 Pleasant Valley Road
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL
8. RESERVED FOR NUCC USE	CITY STATE ID Boise ID
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	CITY STATE ID Boise ID
a. OTHER INSURED'S POLICY OR GROUP NUMBER	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
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 05 31 2021	11. INSURED'S POLICY GROUP OR FECA NUMBER ██████████ 1607 a. INSURED'S DATE OF BIRTH (MM   DD   YY) ████ 1607 SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM   DD   YY) 05 31 2021 QUAL 431	15. OTHER DATE (MM   DD   YY) QUAL
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM   DD   YY) FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD Ind. 0 A. I R55 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83704
24. A. DATE(S) OF SERVICE From To 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. EFSOT Family Pmt I. ID. QUAL J. RENDERING PROVIDER ID. #	
1. 05312021 05312021 41 Y A0427 SH A 1205 18 1 NPI	AMBULANCE SERVICE - ALS1
2. 05312021 05312021 41 Y A0425 SH A 40 10 2.8 NPI	MILEAGE
3. NPI	
4. NPI	
5. NPI	
6. NPI	
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 542A
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	28. TOTAL CHARGE \$ 1245 28
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 04 20 2023	32. SERVICE FACILITY LOCATION INFORMATION FROM: 303 N Kimball Pl Boise, ID 83704 TO: 1055 N Curtis Road Boise, ID 83704-1309
SIGNED DATE	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. 9987 b.

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA EXCLUDING <input checked="" type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 251D																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ASH TERRY I.						3. PATIENT'S BIRTH DATE MM DD YY 06 12 1957	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ASH TERRY I.															
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd															
CITY Kuna		STATE ID		8. RESERVED FOR NUCC USE		CITY Kuna		STATE ID															
ZIP CODE 83634		TELEPHONE (Include Area Code) (208) 389-0229		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		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon		11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S DATE OF BIRTH MM DD YY 06 12 1957															
a. INSURED'S DATE OF BIRTH MM DD YY 06 12 1957		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>															
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 06-12-2021						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 06 12 2021			15. OTHER DATE QUAL 431			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. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. R4020						22. RESUBMISSION CODE ORIGINAL REF. NO.																	
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. EP/SOT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1		06122021		06122021		41		Y		A0427		EH		A		1258.23		1		NPI			
2		06122021		06122021		41		Y		A0425		EH		A		189.02		13.2		NPI			
3																				NPI			
4																				NPI			
5																				NPI			
6																				NPI			
25. FEDERAL TAX I.D. NUMBER 0277			SSN EIN <input checked="" type="checkbox"/>			26. PATIENT'S ACCOUNT NO. 276A			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. TOTAL CHARGE \$ 1447.25		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498											
SIGNED DATE 05 09 2023						SIGNED DATE 09987																	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 201D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>ANDERSON RIO J</b>					3. PATIENT'S BIRTH DATE [REDACTED] 1997 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ANDERSON RIO J</b>									
5. PATIENT'S ADDRESS (No., Street) <b>2366 E Old Penitentiary Rd</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) <b>2366 E Old Penitentiary Rd</b>									
CITY <b>Boise</b>		STATE <b>ID</b>		CITY <b>Boise</b>		STATE <b>ID</b>		ZIP CODE <b>83712</b>		TELEPHONE (Include Area Code) <b>(208) 900-8629</b>		CITY <b>Boise</b>		STATE <b>ID</b>		ZIP CODE <b>83712</b>		TELEPHONE (Include Area Code) <b>(208) 900-8629</b>	
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH [REDACTED] 1997 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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. SIGNED <b>SIGNATURE ON FILE</b> DATE <b>06 13 2021</b>										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 <b>SIGNATURE ON FILE</b>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>06 13 2021</b> QUAL <b>431</b>					15. OTHER DATE QUAL 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: NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					17b: NPI					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. <b>0</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. <b>R112</b> B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER <b>83712</b>									
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)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT (Form/Plan)		I. ID. QUAL		J. RENDERING PROVIDER ID.#	
1		06132021		06132021		41 Y		A0427 SH A		978 15		1		NPI					
2		06132021		06132021		41 Y		A0425 SH A		27 21		1.9		NPI					
3														NPI					
4														NPI					
5														NPI					
6														NPI					
25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>377A</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
28. TOTAL CHARGE \$ <b>1005 36</b>					29. AMOUNT PAID \$ <b>0 00</b>					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.) <b>ADA County Paramedics</b> 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 2366 E Old Penitentiary Rd Boise, ID 83712</b> <b>TO: 190 E Bannock Street Boise, ID 83712-6241</b>					33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>9987</b>				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLX LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 34TD							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Nosalskiy Walter I						3. PATIENT'S BIRTH DATE MM DD YY 1993 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO									
5. PATIENT'S ADDRESS (No., Street) 617 S Roosevelt Street CITY Boise STATE ID ZIP CODE 83705 TELEPHONE (Include Area Code) (208) 284-0668						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Nosalskiy Walter I						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
a. OTHER INSURED'S POLICY OR GROUP NUMBER 0303						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
b. RESERVED FOR NUCC USE						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 06-13-2021						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									
c. RESERVED FOR NUCC USE						14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 13 2021 QUAL 431						15. OTHER DATE MM DD YY									
d. INSURANCE PLAN NAME OR PROGRAM NAME Division of Medicaid						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									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R45851 B. C. D. ICD ind. 0 E. F. G. H. J. K. L.						22. RESUBMISSION CODE ORIGINAL REF. NO.						23. PRIOR AUTHORIZATION NUMBER 83634									
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/HCPSS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 06132021 06132021		41		Y		AMBULANCE SERVICE - ALS1 A0427 EH A 978 15 1										NPI					
2 06132021 06132021		41		Y		MILEAGE A0425 EH A 191 89 13.4										NPI					
3																NPI					
4																NPI					
5																NPI					
6																NPI					
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. 485A						27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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.) ADA County Paramedics 05 09 2023						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 08 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SONNIP JESSE										3. PATIENT'S BIRTH DATE (MM DD YY) 1985 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
5. PATIENT'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd CITY Kuna STATE ID										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd CITY Kuna STATE ID										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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH (MM DD YY) 1985 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE DATE 06-14-2020										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE   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) 06-14-2021 QUAL 431										15. OTHER DATE									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service lines below (24E) A. K922 B. C. D. ICD ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1 06142021 06142021 41 Y A0427 SH A 978 15 1 NPI										AMBULANCE SERVICE = ALS1									
2 06142021 06142021 41 Y A0425 SH A 196 18 13.7 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 568A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1174 33									
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N. Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287-2950										33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									
SIGNED DATE 05 09 2023										9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 73 ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) WATRING SHERRI L		3. PATIENT'S BIRTH DATE MM DD YY 1966 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )		4. INSURED'S NAME (Last Name, First Name, Middle Initial) WATRING SHERRI L 7. INSURED'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )	
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 checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon	
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 06 14 2021 QUAL 431		15. OTHER DATE QUAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD ind: 0 A. R52 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-0000	
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. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 06142021 06142021 41 Y A0429 EH A 737 32 1 NPI			
2 06142021 06142021 41 Y A0425 EH A 187 59 13.1 NPI			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER : SSN EIN 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 579A	
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.) ADA County Paramedics 05 09 2023 SIGNED _____ DATE _____		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309		28. TOTAL CHARGE \$ 924 91 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use	
		33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987	

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 401D	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hites Maynard L		3. PATIENT'S BIRTH DATE (MM/DD/YY) 1946 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX	
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
CITY: Kuna STATE: ID		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter	
ZIP CODE: 83634 TELEPHONE (include Area Code): ( )		7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL	
CITY: Kuna STATE: ID		CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (include Area Code): ( )		ZIP CODE: 83707 TELEPHONE (include Area Code): (208) 331-2760	
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 checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER ██████████ 1607		a. INSURED'S DATE OF BIRTH (MM/DD/YY) _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>	
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.		b. OTHER CLAIM ID (Designated by NUCC)	
SIGNED _____ DATE _____		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
		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 06 14 2021 QUAL 431		15. OTHER DATE QUAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I6789 B. C. D. E. F. G. H. I. J. ICD ind 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER 83634			

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
06142021 06142021	41	Y	A0427 SH	A	978 15	1		NPI	
06142021 06142021	41	Y	A0425 SH	A	161 82	11.3		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ██████████ 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. ██████████ 655A		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1139 97		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987			

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 311D																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MITCHELL CHRISTOPHER										3. PATIENT'S BIRTH DATE (MM DD YY) 1995 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX																													
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>																													
CITY Kuna					STATE ID					7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL					CITY Boise					STATE ID																			
ZIP CODE 83634					TELEPHONE (Include Area Code) ( )					ZIP CODE 83707					TELEPHONE (Include Area Code) (208) 331-2760																								
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH (MM DD YY) M <input type="checkbox"/> F <input type="checkbox"/> SEX																			
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? (PLACE (State)) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO // Yes, complete items 9, 9a, and 9d.																			
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 06-17-2021																				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 06 17 2021 QUAL 431										15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. R079 B. C. D. E. F. G. H. I. J. K. L.										ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PERSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER 83634																													
1 06172021 06172021 41 Y A0427 SH A 1140 47 1 NPI										AMBULANCE SERVICE - ALS1																													
2 06172021 06172021 41 Y A0425 SH A 189 02 13.2 NPI										MILEAGE																													
3										NPI																													
4										NPI																													
5										NPI																													
6										NPI																													
25. FEDERAL TAX I.D. NUMBER 0277										26. PATIENT'S ACCOUNT NO. 102A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					28. TOTAL CHARGE \$ 1329 49					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																			
SIGNED										DATE 05 09 2023										9987																			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA B/LK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 54 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Joyce Jourdan										3. PATIENT'S BIRTH DATE (MM DD YY) 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH (MM DD YY) 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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 06 23 2021										11. INSURED'S POLICY GROUP OR FECA NUMBER									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 23 2021 QUAL 431										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service-line below (24E) ICD (nd) 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
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) GPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
1 06232021 06232021 41 Y AMBULANCE SERVICE - ALS1 A0427 SH A 1140 47 1 NPI																			
2 06232021 06232021 41 Y MILEAGE A0425 SH A 194 75 13.6 NPI																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 932A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1335 22									
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
SIGNED										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 501D	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Murdoch Keisha D		3. PATIENT'S BIRTH DATE MM DD YY 1994 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCT IDAHO 7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195	
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 checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State):	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon	
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 06-23-2021		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 06 23 2021 QUAL 431		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-0000	
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. ICD-9 CM ICD-10 CM ICD-10 PCS J. RENDERING PROVIDER ID. #			
1 06232021 06232021 41 Y A0427 EH A 1140.47 1 NPI			
2 06232021 06232021 41 Y A0425 EH A 197.62 13.8 NPI			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 936A	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1338.09	
29. AMOUNT PAID \$ 0.00		30. Rcvd 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.) ADA County Paramedics 05 09 2023		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309	
33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 94 ID		(For Program in Item 1)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Payne Erik J						3. PATIENT'S BIRTH DATE MM DD YY 1968 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter																		
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL															
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE						CITY Boise			STATE ID												
ZIP CODE 83634			TELEPHONE (Include Area Code) ( )			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						ZIP CODE 83707			TELEPHONE (Include Area Code) (208) 331-2760												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. RESERVED FOR NUCC USE						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>															
b. RESERVED FOR NUCC USE						c. RESERVED FOR NUCC USE						b. OTHER CLAIM ID (Designated by NUCC)															
c. RESERVED FOR NUCC USE						d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon						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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.															
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 06-23-2021												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 06 23 2021 QUAL 431						15. OTHER DATE QUAL 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. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. IS0990XA B. C. D. E. F. G. H. I. J. K. L.												22. RESUBMISSION CODE ORIGINAL REF. NO.															
23. PRIOR AUTHORIZATION NUMBER 83634																											
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 POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPOD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #							
1 06232021 06232021		41		Y		AMBULANCE SERVICE = ALS1 A0427 SH				A		978 15		1		NPI											
2 06232021 06232021		41		Y		MILEAGE A0425 SH				A		189 02		13.2		NPI											
3																NPI											
4																NPI											
5																NPI											
6																NPI											
25. FEDERAL TAX I.D. NUMBER 0277				SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 073A				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 1167 17				29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023												32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 111D												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Bronstad Randy M</b>					3. PATIENT'S BIRTH DATE MM DD YY SEX [REDACTED] 1952 M <input checked="" type="checkbox"/> F <input type="checkbox"/>												
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b> CITY STATE ID <b>Kuna ID</b> ZIP CODE TELEPHONE (Include Area Code) <b>83634 ( )</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>												
7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b> CITY STATE ID <b>Boise ID</b> ZIP CODE TELEPHONE (Include Area Code) <b>83707 (208) 331-2760</b>					8. RESERVED FOR NUCC USE												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ICC ID CorracCenter</b>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>[REDACTED] 11</b>					11. INSURED'S POLICY GROUP OR FECA NUMBER <b>[REDACTED] 1607</b>												
b. RESERVED FOR NUCC USE					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												
c. RESERVED FOR NUCC USE					b. OTHER CLAIM ID (Designated by NUCC)												
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>Centurion of ID IDOC</b>					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>												
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 <b>06 24 2021</b>					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>												
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL <b>06 24 2021 QUAL 431</b>					15. OTHER DATE QUAL MM DD YY												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a: <input type="checkbox"/> 17b: NPI					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. <b>R109</b> B. C. D. ICD Ind. <b>0</b> E. F. G. H. I. J. K. L.					22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER <b>83634</b>												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSON Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID.#	
1		06242021 06242021 41 Y		A0429 EH		A		660 94		1		NPI					
2		06242021 06242021 41 Y		A0425 EH		A		189 02		13.2		NPI					
3												NPI					
4												NPI					
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>[REDACTED] 0277 [REDACTED] X</b>					26. PATIENT'S ACCOUNT NO. <b>[REDACTED] 094A</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
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.) <b>ADA County Paramedics</b> 05 09 2023					32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>					28. TOTAL CHARGE \$ <b>849 96</b> 29. AMOUNT PAID \$ <b>0 00</b> 30. Rsvd for NUCC Use							
SIGNED DATE					33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>[REDACTED] 9987</b>												

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>76ID</b>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>McClain Steven</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1954</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TSCT IDAHO</b>								
5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b>					
CITY <b>Kuna</b>			STATE <b>ID</b>			8. RESERVED FOR NUCC USE			CITY <b>Boise</b>			STATE <b>ID</b>					
ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>						ZIP CODE <b>83707</b>			TELEPHONE (Include Area Code) <b>(208) 331-1195</b>					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY <b>1967</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>					

**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 06 24 2021

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 <b>06 24 2021</b> QUAL <b>431</b>				15. OTHER 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. ICD-10				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b. NPI				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. <b>R079</b> B. C. D. E. F. G. H. I. J. K. L.								22. RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER <b>83634</b>											

1	24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY			CPT/HCPCS	MODIFIER						
1	06242021	06242021	41	Y	A0427	EH	A	1205.18	1		NPI	
2	06242021	06242021	41	Y	A0425	EH	A	196.18	13.7		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>185A</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>1401.36</b>		29. AMOUNT PAID \$ <b>0.00</b>		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.) <b>ADA County Paramedics</b>				32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>				33. BILLING PROVIDER INFO & PH # <b>(208) 287-2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b>			
SIGNED <b>05 09 2023</b> DATE				SIGNED <b>9987</b> b.							

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA  (ID#) PICA  (ID#)

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) **66ID**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Turnboo Travis** 3. PATIENT'S BIRTH DATE (MM/DD/YY) **1987** SEX  M  F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) **ISCI IDAHO**

5. PATIENT'S ADDRESS (No., Street) **13500 S Pleasant Valley Rd** 6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other  7. INSURED'S ADDRESS (No., Street) **ATTN MEDICAL**

CITY **Kuna** STATE **ID** 8. RESERVED FOR NUCC USE CITY **Boise** STATE **ID**

ZIP CODE **83634** TELEPHONE (Include Area Code) **(208) 886-9588** ZIP CODE **83707** TELEPHONE (Include Area Code) **(208) 331-1195**

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **ISCI IDAHO** 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER **66** a. EMPLOYMENT? (Current or Previous)  YES  NO b. AUTO ACCIDENT?  YES  NO PLACE (State) c. OTHER ACCIDENT?  YES  NO

b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME **Centurion of ID IDOC** 10d. CLAIM CODES (Designated by NUCC) 11. INSURED'S DATE OF BIRTH (MM/DD/YY) **1967** SEX  M  F

b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon** d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO If yes, complete items 9, 9a, and 9d.

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 **06 25 2021** SIGNED **SIGNATURE ON FILE**

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) **06 25 2021** QUAL **431** 15. OTHER 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. 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: **0** 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. **R079** B. C. D. E. F. G. H. I. J. K. L. 23. PRIOR AUTHORIZATION NUMBER **83634**

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. EPST/Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #

1 **06252021 06252021 41 Y A0427 EH A 1140 47 1 NPI**

2 **06252021 06252021 41 Y A0425 EH A 196 18 13.7 NPI**

3 **NPI**

4 **NPI**

5 **NPI**

6 **NPI**

25. FEDERAL TAX I.D. NUMBER **0277** SSN EIN   26. PATIENT'S ACCOUNT NO. **251A** 27. ACCEPT ASSIGNMENT? (For gov. claims, see back)  YES  NO 28. TOTAL CHARGE \$ **1336 65** 29. AMOUNT PAID \$ **0 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.) **ADA County Paramedics** 32. SERVICE FACILITY LOCATION INFORMATION **FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309** 33. BILLING PROVIDER INFO & PH # **(208) 287 2950**

SIGNED **05 09 2023** DATE **Boise, ID 83704-1309** **9987**



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 07ID			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Dalton Jacob C						3. PATIENT'S BIRTH DATE (MM DD YY) 1984 M X F			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO					
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL								
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE						CITY Boise			STATE ID		
ZIP CODE 83634			TELEPHONE (Include Area Code) (208) 409-9839									ZIP CODE 83707			TELEPHONE (Include Area Code) (208) 331-1195		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)						11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH (MM DD YY) 1967 M X F						SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. OTHER CLAIM ID (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					
c. RESERVED FOR NUCC USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
d. INSURANCE PLAN NAME OR PROGRAM NAME						12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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 07 01 2021						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 07 01 2021 QUAL 431  
 15. OTHER 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. 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. 0  
 A. R0600 B. C. D. E. F. G. H. I. J. K. L.  
 22. RESUBMISSION CODE ORIGINAL REF. NO.  
 23. PRIOR AUTHORIZATION NUMBER 83634

24. A. DATE(S) OF SERVICE	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. EPST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
07012021 07012021	41	Y	A0427 EH	A	1205 18	1		NPI	
07012021 07012021	41	Y	A0425 EH	A	197 62	13.8		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 233A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1402 80		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 83 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CERVANTES ANGELO										3. PATIENT'S BIRTH DATE SEX MM DD YY M F 1993 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) CERVANTES ANGELO										5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd									
8. RESERVED FOR NUCC USE										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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. INSURED'S DATE OF BIRTH SEX MM DD YY M F 1993 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										b. OTHER CLAIM ID (Designated by NUCC)									
c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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 07 01 2021										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 07 01 2021 QUAL 431										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. S51811A B. C. D. ICD Inc. 0 E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. B3634									
23. PRIOR AUTHORIZATION NUMBER B3634										23. PRIOR AUTHORIZATION NUMBER B3634									
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Frank Plan I. ID: QUAL J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Frank Plan I. ID: QUAL J. RENDERING PROVIDER ID. #									
1 07012021 07012021 41 Y A0427 EH A 978 15 1 NPI										1 07012021 07012021 41 Y A0427 EH A 978 15 1 NPI									
2 07012021 07012021 41 Y A0425 EH A 190 46 13.3 NPI										2 07012021 07012021 41 Y A0425 EH A 190 46 13.3 NPI									
3										3									
4										4									
5										5									
6										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. B39A									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1168 61									
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287 2950										33. BILLING PROVIDER INFO & PH # (208) 287 2950									
SIGNED DATE										SIGNED DATE									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>261D</b>		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Russell Donald B</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1938</b>	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TSCI IDAHO</b>	
5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b>	
CITY <b>Kuna</b>		STATE <b>ID</b>		B. RESERVED FOR NUCC USE		CITY <b>Boise</b>		STATE <b>ID</b>	
ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>(208) 336-0740</b>				ZIP CODE <b>83707</b>		TELEPHONE (Include Area Code) <b>(208) 331-1195</b>	
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		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>		11. INSURED'S DATE OF BIRTH MM DD YY <b>1967</b>	
						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)	
						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>SIGNED SIGNATURE ON FILE</b>						10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>07 02 2021</b>						15. OTHER DATE QUAL MM DD YY <b>07 02 2021</b>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>SIGNED SIGNATURE ON FILE</b>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						17a. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. <b>M79605</b>						17b. NPI		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY						23. PRIOR AUTHORIZATION NUMBER <b>83634</b>			
B. PLACE OF SERVICE						24. B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	
C. EMG						24. C. DATE(S) OF SERVICE From MM DD YY To MM DD YY		F. \$ CHARGES	
D. EMG						24. D. DATE(S) OF SERVICE From MM DD YY To MM DD YY		G. DAYS OR UNITS	
E. EMG						24. E. DATE(S) OF SERVICE From MM DD YY To MM DD YY		H. EPSTI Family Plan	
F. EMG						24. F. DATE(S) OF SERVICE From MM DD YY To MM DD YY		I. ID. QUAL	
G. EMG						24. G. DATE(S) OF SERVICE From MM DD YY To MM DD YY		J. RENDERING PROVIDER ID. #	
H. EMG						24. H. DATE(S) OF SERVICE From MM DD YY To MM DD YY			
I. EMG						24. I. DATE(S) OF SERVICE From MM DD YY To MM DD YY			
J. EMG						24. J. DATE(S) OF SERVICE From MM DD YY To MM DD YY			
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>0277</b>						26. PATIENT'S ACCOUNT NO. <b>496A</b>		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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.) <b>ADA County Paramedics</b>						28. TOTAL CHARGE <b>\$ 1297.99</b>		29. AMOUNT PAID <b>\$ 0.00</b>	
32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b>						30. Rsvd for NUCC Use		33. BILLING PROVIDER INFO & PH # <b>(208) 287-2950</b>	
32. SERVICE FACILITY LOCATION INFORMATION <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>						33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498</b>			
SIGNED DATE <b>05 09 2023</b>						33. BILLING PROVIDER INFO & PH # <b>9987</b>			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#)										1a. INSURED'S I.D. NUMBER 931D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Wolfe William F										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Wolfe William F									
3. PATIENT'S BIRTH DATE MM DD YY 1955 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd										6. RESERVED FOR NUCC USE									
CITY Kuna STATE ID										CITY Kuna STATE ID									
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )										ZIP CODE 83634 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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER 1607										11. INSURED'S DATE OF BIRTH MM DD YY 1955 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
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 SIGNATURE ON FILE DATE 07-04-2021										SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 04 2021 QUAL 431										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. IR0602 B. C. D. E. F. G. H. I. J. K. L.										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										22. RESUBMISSION CODE ORIGINAL REF. NO.									
B. PLACE OF SERVICE										23. PRIOR AUTHORIZATION NUMBER 83634									
C. EMG										24. F. \$ CHARGES									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										G. DAYS OR UNITS									
E. DIAGNOSIS POINTER										H. EPDT Family Plan									
I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1 07042021 07042021 41 Y A0427 EH A 1276 26 1 NPI										AMBULANCE SERVICE - ALS1									
2 07042021 07042021 41 Y A0425 EH A 197 62 13 8 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1473 88									
26. PATIENT'S ACCOUNT NO. 687A										29. AMOUNT PAID \$ 0 00									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										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.) ADA County Paramedics										33. BILLING PROVIDER INFO & PH# (208) 287 2950									
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH# ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									
SIGNED DATE 05 09 2023										9987									

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA B/L LUNG <input checked="" type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 34 ID		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Clausen James D</b>				3. PATIENT'S BIRTH DATE (MM/DD/YY)    SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F [REDACTED] 1965		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ICC ID CorrecCenter</b>						
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b>						
CITY <b>Kuna</b>		STATE <b>ID</b>		8. RESERVED FOR NUCC USE		CITY <b>Boise</b>		STATE <b>ID</b>				
ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>( )</b>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Clausen James D</b>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH (MM/DD/YY)    SEX <input type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC)				
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>1188</b>				b. AUTO ACCIDENT? (PLACE (State)) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>						
b. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
c. RESERVED FOR NUCC USE				d. INSURANCE PLAN NAME OR PROGRAM NAME <b>IDHW</b>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
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 07 06 2021							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 07 06 2021 431					15. OTHER DATE MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
17b. NPI				17c.		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. <b>R079</b> B.    C.    D.    ICD Ind. <b>0</b>					22. RESUBMISSION CODE    ORIGINAL REF. NO.							
E.    F.    G.    H.    I.    J.    K.    L.					23. PRIOR AUTHORIZATION NUMBER <b>83634</b>							
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. PERSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 07062021 07062021		41	Y	AMBULANCE SERVICE - ALS1 A0427 SH			A	1148 96	1	NPI	NPI	
2 07062021 07062021		41	Y	MILEAGE A0425 SH			A	134 61	9.4	NPI	NPI	
3		41	Y	NPI			NPI	NPI	NPI	NPI	NPI	
4		41	Y	NPI			NPI	NPI	NPI	NPI	NPI	
5		41	Y	NPI			NPI	NPI	NPI	NPI	NPI	
6		41	Y	NPI			NPI	NPI	NPI	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER    SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1283 57		29. AMOUNT PAID \$ 0 00		30. Rsvd for NUCC Use		
0277		045A		YES NO		\$ 1283 57		\$ 0 00		33. BILLING PROVIDER INFO & PH # (208) 287 2950		
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.) <b>ADA County Paramedics</b>				32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # (208) 287 2950 <b>ADA COUNTY PARAMEDICS</b> 370 N. Benjamin Lane Boise ID 83704-8498				
SIGNED DATE 05 09 2023				33. BILLING PROVIDER INFO & PH # (208) 287 2950 <b>ADA COUNTY PARAMEDICS</b> 370 N. Benjamin Lane Boise ID 83704-8498				33. BILLING PROVIDER INFO & PH # (208) 287 2950 <b>ADA COUNTY PARAMEDICS</b> 370 N. Benjamin Lane Boise ID 83704-8498				





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLX/LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 21ID			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FISHER DALE						3. PATIENT'S BIRTH DATE MM DD YY 1977 M X F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) IMST Max Security								
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA					
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE			CITY Boise			STATE ID					
ZIP CODE 83634			TELEPHONE (Include Area Code) ( )						ZIP CODE 83707			TELEPHONE (Include Area Code) (208) 389-0230					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M X F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 07-07-2021

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 07 07 2021 431				15. OTHER 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. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. IR109 B. C. D. ICD ind: 0 E. F. G. H. I. J. K. L.								22. RESUBMISSION CODE ORIGINAL REF. NO.							
23. PRIOR AUTHORIZATION NUMBER 83634-2716															

	24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ESOT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY			CPT/HCPCS	MODIFIER						
1	07072021	07072021	41	Y	A0429	EH	A	650.94	1		NPI	
2	07072021	07072021	41	Y	A0425	EH	A	187.59	13.1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 228A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 848.53		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA																																																																																									
1. MEDICARE <input type="checkbox"/> (Medicare#)										MEDICAID <input type="checkbox"/> (Medicaid#)										TRICARE <input type="checkbox"/> (ID#/DoD#)										CHAMPVA <input type="checkbox"/> (Member ID#)										GROUP HEALTH PLAN <input type="checkbox"/> (ID#)										FECA BLK LUNG <input type="checkbox"/> (ID#)										OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 8875										(For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Webb Julia																				3. PATIENT'S BIRTH DATE MM DD YY 1969 M <input type="checkbox"/> F <input checked="" type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Webb Julia																																																																					
5. PATIENT'S ADDRESS (No., Street) 13200 S Pleasant Valley Rd CITY Kuna STATE ID																				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 13200 S Pleasant Valley Rd CITY Kuna STATE ID																																																																					
8. RESERVED FOR NUCC USE										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY 1969 M <input type="checkbox"/> F <input checked="" type="checkbox"/>										13. OTHER CLAIM ID (Designated by NUCC)																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 07 2021 QUAL 431										15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. IR0602 B. C. D. E. F. G. H. I. J. K. L. ICD Ind: 0										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 83634-2720																																																	
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. EPSON Family Plan										I. ID. QUAL										J. RENDERING PROVIDER ID. #									
1 07072021 07072021 41 Y										AMBULANCE SERVICE - ALS1										A0427 EH A										1205 18 1										NPI																																																											
2 07072021 07072021 41 Y										MILEAGE										A0425 EH A										179 00 12.5										NPI																																																											
3																																																																																																			
4																																																																																																			
5																																																																																																			
6																																																																																																			
25. FEDERAL TAX I.D. NUMBER 0277										SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 266A										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1384 18										29. AMOUNT PAID \$ 0 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.) ADA County Paramedics																				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13200 S Pleasant Valley Rd Kuna, ID 83634-2720 TO: 1055 N Curtis Road Boise, ID 83704-1309																				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987																																																											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>					1a. INSURED'S I.D. NUMBER 511D					1b. INSURED'S NAME (Last Name, First Name, Middle Initial) TMST Max Security					7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Shiffer Timothy P					3. PATIENT'S BIRTH DATE MM DD YY 1954 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S ADDRESS (No., Street) ATTEN DIANNA					STATE ID																								
5. PATIENT'S ADDRESS (No., Street) PO Box 70010					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					CITY Boise					STATE ID																								
CITY Boise					STATE ID					CITY Boise					STATE ID																								
ZIP CODE 83707					TELEPHONE (Include Area Code) (208) 972-2519					ZIP CODE 83707					TELEPHONE (Include Area Code) (208) 389-0230																								
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					12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # Yes, complete items 9, 9a, and 9c.																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>					b. OTHER CLAIM ID (Designated by NUCC)																								
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # Yes, complete items 9, 9a, and 9c.																								
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					14. 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.																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					SIGNED SIGNATURE ON FILE					SIGNED SIGNATURE ON FILE																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 08 2021 QUAL 1431					15. OTHER DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER 83634																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. E162 B. C. D. ICD ind. 0					22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER 83634					24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Psn I. ID. QUAL J. RENDERING PROVIDER ID. #																								
1 07082021 07082021 41 Y A0429 SH A 660 94 1 NPI					2 07082021 07082021 41 Y A0425 SH A 189 02 13 2 NPI					3 NPI					4 NPI																								
5 NPI					6 NPI					25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 295A					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 849 96					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics					32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise ID 83704-1309					33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498					SIGNED DATE 05 09 2023					SIGNED DATE 05 09 2023																			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 42ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Pena Jose A										3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 1986 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO										5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL									
8. RESERVED FOR NUCC USE										CITY STATE ID Boise									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
11. INSURED'S POLICY GROUP OR FECA NUMBER 1607										12. PATIENT'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 DATE 07 08 2021									
13. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) QUAL 07 08 2021 QUAL 431									
15. OTHER DATE (MM/DD/YY) QUAL										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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.									
22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 83634									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ERST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28. TOTAL CHARGE \$ 1312 31 29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH# (208) 287 2950										34. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. 9987 b.									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA B/L KLUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program In Item 1) 8875									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Williford Christian M										3. PATIENT'S BIRTH DATE (MM DD YY) 1999 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID										4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter 7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY Boise STATE ID									
8. RESERVED FOR NUCC USE										11. INSURED'S POLICY GROUP OR FECA NUMBER 83707 (208) 331-2760									
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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 07 08 2021										11. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 08 2021 QUAL 431										15. OTHER DATE QUAL: MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
A. G8911 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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. EPSTI Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER 83634									
1 07082021 07082021 41 Y A0429 EH A 669 43 1 NPI										AMBULANCE SERVICE - BLS									
2 07082021 07082021 41 Y A0425 EH A 180 43 12 6 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 363A 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 849 86 29. AMOUNT PAID \$ 0 00 30. Rcvd 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
SIGNED DATE 05 09 2023										33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA  PICA

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER   
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) OGDEN LAURIE A  
3. PATIENT'S BIRTH DATE (MM/DD/YY) 1967 M  F  SEX  
4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO

5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd  
6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL  
CITY STATE ID  
Kuna ID

8. RESERVED FOR NUCC USE  
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OGDEN LAURIE A  
10. IS PATIENT'S CONDITION RELATED TO:  
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER 6464  
a. EMPLOYMENT? (Current or Previous) YES  NO

b. RESERVED FOR NUCC USE  
b. AUTO ACCIDENT? YES  NO  PLACE (State)  
c. RESERVED FOR NUCC USE  
c. OTHER ACCIDENT? YES  NO

d. INSURANCE PLAN NAME OR PROGRAM NAME IDHW  
10d. CLAIM CODES (Designated by NUCC)  
11. INSURED'S DATE OF BIRTH (MM/DD/YY) 1967 M  F  SEX  
12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES  NO  If yes, complete items 9, 9a, and 9d.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  
SIGNATURE ON FILE DATE 07 09 2021

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 07 09 2021 QUAL 431  
15. OTHER DATE MM/DD/YY  
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO  
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI  
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 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. 0  
A: R4182 B: C: D:  
E: F: G: H:  
I: J: K: L:

22. RESUBMISSION CODE ORIGINAL REF. NO.  
23. PRIOR AUTHORIZATION NUMBER 83634

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EP(SD) Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#

1 07092021 07092021 41 Y A0427 EH A 1042 86 1 NPI  
2 07092021 07092021 41 Y A0425 EH A 170 41 11.9 NPI

3  
4  
5  
6

25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN  26. PATIENT'S ACCOUNT NO. 459A 27. ACCEPT ASSIGNMENT? YES  NO  (For gov. claims, see back)

28. TOTAL CHARGE \$ 1213 27 29. AMOUNT PAID \$ 0 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.) ADA County Paramedics  
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309  
33. BILLING PROVIDER INFO & PH # (208) 287 2950 370 N. Benjamin Lane Boise ID 83704-8498

SIGNED DATE 05 09 2023

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA B/L LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 541D																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) WILLIAMSON PAULA M										3. PATIENT'S BIRTH DATE MM DD YY 1969 M <input type="checkbox"/> F <input checked="" type="checkbox"/>																													
5. PATIENT'S ADDRESS (No., Street) 13200 S Pleasant Valley Rd CITY Kuna STATE ID										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>																													
4. INSURED'S NAME (Last Name, First Name, Middle Initial) PRISON DOC WOMENS										7. INSURED'S ADDRESS (No., Street) ATTEN LARRY HEINZ CITY Boise STATE ID																													
8. RESERVED FOR NUCC USE										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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)																													
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER																													
a. INSURED'S DATE OF BIRTH MM DD YY										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>																													
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)																													
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 8, 9a, and 9d.																													
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 07-09-2021																				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 07 09 2021 QUAL 431										15. OTHER DATE QUAL: MM DD YY																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. T71162A B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.																													
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. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER 83634-2720																													
1 07092021 07092021 41 Y A0427 EH A 1216.85 1 NPI										AMBULANCE SERVICE - ALS1																													
2 07092021 07092021 41 Y A0425 EH A 177.57 12.4 NPI										MILEAGE																													
3										NPI																													
4										NPI																													
5										NPI																													
6										NPI																													
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 548A																													
27. ACCEPT ASSIGNMENT? (For gov. claims see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1394.42 29. AMOUNT PAID \$ 0.00 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13200 S Pleasant Valley Rd Kuna, ID 83634-2720 TO: 1055 N Curtis Road Boise, ID 83704-1309																													
33. BILLING PROVIDER INFO & PH # (208) 287-2950										33. BILLING PROVIDER INFO & PH # (208) 287-2950																													
SIGNED DATE 05 09 2023										33. BILLING PROVIDER INFO & PH # (208) 287-2950																													

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>																			
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 07 ID														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>CANTU SANTANA</b>					3. PATIENT'S BIRTH DATE (MM DD YY) SEX 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TJCT IDAHO</b>												
5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b>												
CITY <b>Kuna</b>			STATE <b>ID</b>		8. RESERVED FOR NUCC USE			CITY <b>Boise</b>		STATE <b>ID</b>									
ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			11. INSURED'S POLICY GROUP OR FECA NUMBER <b>07</b>			a. INSURED'S DATE OF BIRTH (MM DD YY) SEX <b>1967</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>										
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE			b. OTHER CLAIM ID (Designated by NUCC)										
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										
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 <b>SIGNATURE ON FILE</b> DATE <b>07-11-2021</b>										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 <b>SIGNATURE ON FILE</b>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>07 11 2021</b> QUAL <b>431</b>					15. OTHER 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.					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
17b. NPI					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. <b>R079</b> B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER <b>83634</b>									
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. ICD-9-CM Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID.#	
<b>07112021 07112021</b>		<b>41</b>		<b>Y</b>		<b>A0427 EH</b>		<b>A</b>		<b>1140.47</b>		<b>1</b>		<b>NPI</b>					
<b>07112021 07112021</b>		<b>41</b>		<b>Y</b>		<b>A0425 EH</b>		<b>A</b>		<b>196.18</b>		<b>13.7</b>		<b>NPI</b>					
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>0277</b> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>855A</b>					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
28. TOTAL CHARGE \$ <b>1336.65</b>					29. AMOUNT PAID \$ <b>0.00</b>					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.) <b>ADA County Paramedics</b> 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>					33. BILLING PROVIDER INFO & PH # <b>(208) 287-2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
CARRIER

PICA (Medicare#) PICA (Medicaid#) PICA (ID#/DoD#) PICA (Member ID#) PICA (Health Plan ID#) PICA (FECA BLK LUNG ID#) PICA (OTHER ID#)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 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 SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE 8. RESERVED FOR NUCC USE CITY STATE CITY STATE

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) a. INSURED'S DATE OF BIRTH SEX

b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? 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?

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.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE QUAL: 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E). ICD Ind: 0 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS F. \$ CHARGES G. DAYS OR UNITS H. EPST/ Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #

1 07/22/2021 07/22/2021 41 Y A0427 EH A 978 15 1 NPI

2 07/22/2021 07/22/2021 41 Y A0425 EH A 197 62 13.8 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? 28. TOTAL CHARGE 29. AMOUNT PAID 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 #

ADA County Paramedics 05 09 2023 FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498

SIGNED DATE 9987



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>22ID</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Neal Antonio T</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ICC ID CorrecCenter</b>	
3. PATIENT'S BIRTH DATE MM DD YY <b>1974 M X F</b>		7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b>	
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY STATE ID <b>Kuna ID</b>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
CITY STATE ID <b>Boise ID</b>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
ZIP CODE TELEPHONE (Include Area Code) <b>83634 ( )</b>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. OTHER CLAIM ID (Designated by NUCC)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>	
b. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
c. RESERVED FOR NUCC USE		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. <b>SIGNED SIGNATURE ON FILE DATE 07 14 2021</b>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>SIGNED SIGNATURE ON FILE</b>	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL  
**07 14 2021 QUAL 431**

15. OTHER DATE MM DD YY  
QUAL

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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES  
 YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: 0  
A. **R52** B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.  
23. PRIOR AUTHORIZATION NUMBER  
**83634**

24. A. DATE(S) OF SERVICE	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. EPST/ Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
07142021 07142021	41	Y	A0429 SH	A	660 94	1		NPI	
07142021 07142021	41	Y	A0425 SH	A	187 59	13.1		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER <b>0277</b>	SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. <b>258A</b>	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ <b>848 53</b>	29. AMOUNT PAID \$ <b>0 00</b>	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.) <b>ADA County Paramedics</b>		32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>		33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>9987</b>		

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input type="checkbox"/> (ID#)					OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 22ID				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Neal Antonio T										3. PATIENT'S BIRTH DATE MM DD YY ██████████ 1974 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					SEX					4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter																			
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL					CITY STATE ID Boise ID																			
CITY Kuna					STATE ID					8. RESERVED FOR NUCC USE					CITY STATE ID Boise ID					TELEPHONE (Include Area Code) ZIP CODE 83634 ( )					TELEPHONE (Include Area Code) ZIP CODE 83707 (208) 331-2760														
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)					a. INSURED'S DATE OF BIRTH MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>																								
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																								
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT?					c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																													
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 07 15 2021										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 07 15 2021 QUAL 431					15. OTHER DATE QUAL 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. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. IT50902A B. C. D. ICD ind 0 E. F. G. H. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER 83634																								
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 POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #																				
1 07152021 07152021		41		Y		AMBULANCE SERVICE - ALS1 A0427 SH A			1140.47		1		NPI																										
2 07152021 07152021		41		Y		MILEAGE A0425 SH A			446.78		31.2		NPI																										
3													NPI																										
4													NPI																										
5													NPI																										
6													NPI																										
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 386A					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 1587.25					29. AMOUNT PAID \$ 0.00					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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309					33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987																								

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA \_\_\_\_\_ 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) **63 ID**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **MILLER GARRY R** 3. PATIENT'S BIRTH DATE (MM/DD/YY) **1963** SEX  M  F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) **ISCT IDAHO**

5. PATIENT'S ADDRESS (No., Street) **13500 S Pleasant Valley Rd** 6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other  7. INSURED'S ADDRESS (No., Street) **ATTN MEDICAL**

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE  
**Kuna ID** **Boise ID**

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  
**83634** **( )** **83707** **(208) 331-1195**

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)  YES  NO b. AUTO-ACCIDENT?  YES  NO PLACE (State) c. OTHER ACCIDENT?  YES  NO c. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**

b. RESERVED FOR NUCC USE b. OTHER CLAIM ID (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO If yes, complete items 9, 9a, and 9d.

c. RESERVED FOR NUCC USE c. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**

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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described 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 SIGNATURE ON FILE DATE **07 18 2021** 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 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. 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. **0** 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. **R079** B. C. D. E. F. G. H. I. J. K. L. 23. PRIOR AUTHORIZATION NUMBER **83634**

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. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #

1 07/18/2021 07/18/2021 41 Y **AMBULANCE SERVICE - ALS1** A0427 EH A 1140.47 1 NPI

2 07/18/2021 07/18/2021 41 Y **MILEAGE** A0425 EH A 196.18 13.7 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER **0277** SSN EIN  26. PATIENT'S ACCOUNT NO. **815A** 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO 28. TOTAL CHARGE \$ **1336.65** 29. AMOUNT PAID \$ **0.00** 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.) **ADA County Paramedics** 32. SERVICE FACILITY LOCATION INFORMATION FROM: **13500 S PLEASANT VALLEY RD Kuna, ID 83634** TO: **1055 N Curtis Road Boise, ID 83704-1309** 33. BILLING PROVIDER INFO & PH # **(208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498**

SIGNED DATE **05 09 2023** SIGNED DATE **9987**



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

<input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (Group Health Plan ID#) <input type="checkbox"/> (FECA BLK LUNG ID#) <input checked="" type="checkbox"/> (OTHER ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 32 ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V	
3. PATIENT'S BIRTH DATE (MM DD YY) 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) PO Box 51	
5. PATIENT'S ADDRESS (No., Street) PO Box 51		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE ID Boise ID		CITY STATE ID Boise ID	
ZIP CODE TELEPHONE (Include Area Code) 83707 (208) 233-6909		ZIP CODE TELEPHONE (Include Area Code) 83707 (208) 233-6909	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 5141		a. INSURED'S DATE OF BIRTH (MM DD YY) 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA HEALTH CARE		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
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 07 19 2021		11. INSURED'S POLICY GROUP OR FECA NUMBER 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) 07 19 2021 QUAL 431		15. OTHER DATE (MM DD YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. R079 B. C. D. E. F. G. H. I. J. K. L. ICD Ind. 0		20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634	
1 AMBULANCE SERVICE - ALS1 07192021 07192021 41 Y A0427 EH A 1140 47 1 NPI		24. 2 MILEAGE 07192021 07192021 41 Y A0425 EH A 189 02 13 2 NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277		26. PATIENT'S ACCOUNT NO. 934A	
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.) ADA County Paramedics 05 09 2023 DATE Boise, ID 83704-1309		27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-8498		28. TOTAL CHARGE \$ 1329 49 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use	
33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane		30. Rsvd for NUCC Use	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER [REDACTED] 91 ID			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O'NEILL ALEXANDER						3. PATIENT'S BIRTH DATE [REDACTED] 1991 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) O'NEILL ALEXANDER								
6. PATIENT'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd								
CITY Kuna		STATE ID		6. RESERVED FOR NUCC USE		CITY Kuna		STATE ID		6. RESERVED FOR NUCC USE		CITY Kuna		STATE ID			
ZIP CODE 83634		TELEPHONE (Include Area Code) ( )		6. RESERVED FOR NUCC USE		ZIP CODE 83634		TELEPHONE (Include Area Code) ( )		6. RESERVED FOR NUCC USE		ZIP CODE 83634		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH [REDACTED] 1991 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 07.22.2021

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 07 22 2021 QUAL 431		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES	
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. T50901A B. C. D. ICD ind 0						22. RESUBMISSION CODE		ORIGINAL REF. NO.	
E. F. G. H. I. J. K. L.						23. PRIOR AUTHORIZATION NUMBER 83634			

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDY (Family Plan)	I. ID. QUAL	J. RENDERING PROVIDER ID. #
07222021   07222021	41	Y	A0427 SH	A	978 15	1		NPI	
07222021   07222021	41	Y	A0425 SH	A	196 18	13.7		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER [REDACTED] 0277		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. [REDACTED] 454A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1174 33		29. AMOUNT PAID \$ 0 00		30. Rsvd for NUCC Use	
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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.) ADA County Paramedics				32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [REDACTED] 9987			
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CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA	PICA
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BK/LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 911D
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Bennett Steven J	3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] 1970 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter	5. PATIENT'S ADDRESS (No., Street) 14601 Pleasant Valley Road CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 514-1303
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760
8. RESERVED FOR NUCC USE	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Bennett Steven J
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State): c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon
12. PATIENT'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 DATE 07 23 2021	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 07 23 2021 QUAL 431	15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A: R079 B: C: D: E: F: G: H: I: J: K: L:
22. RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER 83634
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) GPT/HCPCS E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ICD ID. QUAL J. RENDERING PROVIDER ID. #	25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN [REDACTED]
26. PATIENT'S ACCOUNT NO. 7540A	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
28. TOTAL CHARGE \$ 1401.36	29. AMOUNT PAID \$ 0.00
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.) ADA County Paramedics 05 09 2023
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE  (Medicare#) MEDICAID  (Medical#) 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) **481D**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Navejar Pete** 3. PATIENT'S BIRTH DATE **1959** SEX  M  F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) **Navejar Pete**

5. PATIENT'S ADDRESS (No., Street) **575 S 13th St** 6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other  7. INSURED'S ADDRESS (No., Street) **575 S 13th St**

CITY **Boise** STATE **ID** 8. RESERVED FOR NUCC USE CITY **Boise** STATE **ID**

ZIP CODE **83702** TELEPHONE (Include Area Code) **(208) 286-6738** 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **Navejar Pete** 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY, GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER **4847** a. EMPLOYMENT? (Current or Previous)  YES  NO a. INSURED'S DATE OF BIRTH **1959** SEX  M  F

b. RESERVED FOR NUCC USE b. AUTO ACCIDENT?  YES  NO PLACE (State) c. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE c. OTHER ACCIDENT?  YES  NO c. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**

d. INSURANCE PLAN NAME OR PROGRAM NAME **IDHW** 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO If yes, complete items 9, 9a, and 9d.

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 **07 23 2021**

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 **07 23 2021** QUAL **431** 15. OTHER DATE QUAL 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. 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. **0** 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. **R531** B. C. D. E. F. G. H. I. J. K. L. 23. PRIOR AUTHORIZATION NUMBER **83634**

24. A. DATE(S) OF SERVICE	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. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
07232021   07232021	41	Y	A0429   EH	A	660 94	1		NPI	
07232021   07232021	41	Y	A0425   EH	A	196 18	13.7		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER **0277** SSN EIN  26. PATIENT'S ACCOUNT NO. **542A** 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO 28. TOTAL CHARGE \$ **857 12** 29. AMOUNT PAID \$ **0 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.) **ADA County Paramedics** 32. SERVICE FACILITY LOCATION INFORMATION FROM: **13500 S PLEASANT VALLEY RI Kuna, ID 83634** TO: **1055 N Curtis Road Boise, ID 83704-1309** 33. BILLING PROVIDER INFO & FH # **(208) 287 2950** **ADA COUNTY PARAMEDICS** **370 N. Benjamin Lane Boise ID 83704-8498**

SIGNED **05 09 2023** DATE **Boise, ID 83704-1309** **9987**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>93ID</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>SAVEDRA EDDIE</b>				3. PATIENT'S BIRTH DATE (MM DD YY)    SEX <b>1995</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ISCT IDAHO</b>					
5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b> CITY: <b>Kuna</b> STATE: <b>ID</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b> CITY: <b>Boise</b> STATE: <b>ID</b>					
ZIP CODE: <b>83634</b>		TELEPHONE (Include Area Code): <b>( )</b>		ZIP CODE: <b>83707</b>		TELEPHONE (Include Area Code): <b>(208) 331-1195</b>					
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		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH (MM DD YY)    SEX <b>1967</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>		b. AUTO ACCIDENT? (PLACE (State)) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>											
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 <b>SIGNATURE ON FILE</b> DATE <b>07-24-2021</b>					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 <b>SIGNATURE ON FILE</b>						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY    QUAL <b>07 24 2021</b> <b>431</b>			15. OTHER DATE MM DD YY    QUAL _____    _____			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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. <b>S0990XA</b> B. _____    C. _____    D. _____ E. _____    F. _____    G. _____    H. _____ I. _____    J. _____					22. RESUBMISSION CODE    ORIGINAL REF. NO. _____    _____						
23. PRIOR AUTHORIZATION NUMBER <b>83634</b>											
24. A. DATE(S) OF SERVICE From MM DD YY    To MM DD YY		B. PLACE OF SERVICE _____	C. EMG <input type="checkbox"/>	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PERSON FROM FEE?	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1    07242021    07242021    41    Y    A0427    EH    A    1054.53    1    NPI											
2    07242021    07242021    41    Y    A0425    EH    A    196.18    13.7    NPI											
3    _____    _____    _____    _____    _____    _____    _____    _____    _____    _____											
4    _____    _____    _____    _____    _____    _____    _____    _____    _____    _____											
5    _____    _____    _____    _____    _____    _____    _____    _____    _____    _____											
6    _____    _____    _____    _____    _____    _____    _____    _____    _____    _____											
25. FEDERAL TAX I.D. NUMBER    SSN EIN <b>0277</b> <input checked="" type="checkbox"/>			26. PATIENT'S ACCOUNT NO. <b>730A</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>1250.71</b>		29. AMOUNT PAID \$ <b>0.00</b>		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.) <b>ADA County Paramedics</b> 05 09 2023			32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>			33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>					



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																							
1. MEDICARE (Medicare#) <input type="checkbox"/>					MEDICAID (Medicaid#) <input type="checkbox"/>					TRICARE (ID#/DoD#) <input type="checkbox"/>					CHAMPVA (Member ID#) <input type="checkbox"/>					GROUP HEALTH PLAN (ID#) <input type="checkbox"/>					FECA BLK LUNG (ID#) <input checked="" type="checkbox"/>					OTHER (ID#) <input checked="" type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 811D														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Ridgley Lee A															3. PATIENT'S BIRTH DATE (MM DD YY) 1954 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCC ID CorrecCenter																								
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY Kuna STATE ID															6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY Boise STATE ID																								
ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 831-1195															8. RESERVED FOR NUCC USE										ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760																								
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH (MM DD YY) M <input type="checkbox"/> F <input type="checkbox"/>																								
b. RESERVED FOR NUCC USE															b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. OTHER CLAIM ID (Designated by NUCC)																								
c. RESERVED FOR NUCC USE															c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																								
d. INSURANCE PLAN NAME OR PROGRAM NAME															10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																								
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 07-24-2021																									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) 07 24 2021 QUAL 431															15. OTHER 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. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)																								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R0602 B. C. D. E. F. G. H. I. J. K. L.															ICD ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.																								
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #															20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										23. PRIOR AUTHORIZATION NUMBER 83634																								
1 07242021 07242021 41 Y A0427 SH A 978 15 1 NPI															AMBULANCE SERVICE - ALS1																																		
2 07242021 07242021 41 Y A0425 SH A 187 59 13 1 NPI															MILEAGE																																		
3																																																	
4																																																	
5																																																	
6																																																	
25. FEDERAL TAX I.D. NUMBER 0277										SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 749A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 1165 74					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023															32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N. Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987																								

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 52 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) NEEP DANNY H										3. PATIENT'S BIRTH DATE (MM DD YY) 1956 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd Kuna ID 83634 TELEPHONE (Include Area Code): (208) 336-1260										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCT IDAHO										7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL Boise ID 83707 TELEPHONE (Include Area Code): (208) 331-1195									
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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon									
12. PATIENT'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 DATE 07 25 2021										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) 07 25 2021 QUAL 431										15. OTHER DATE QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ind. 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
24. A. DATE(S) OF SERVICE From To 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. PERSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 07252021 07252021 41 Y A0427 EH A 1247 62 1 NPI										AMBULANCE SERVICE - ALS1									
2 07252021 07252021 41 Y A0425 EH A 196 18 13.7 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 819A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1443 80									
29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH# (208) 287 2950										ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 101D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mygrant Charlotte A										3. PATIENT'S BIRTH DATE (MM DD YY) SEX 1956 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 13900 Pleasant Valley Rd Boise ID 83709 TELEPHONE (Include Area Code) (208) 334-2731										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) ATTEN VAUGHN Boise ID 83707 TELEPHONE (Include Area Code) (208) 333-0037									
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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
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 07-27-2021										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 07 27 2021 QUAL 431										15. OTHER DATE (MM DD YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R7989 B. C. D. E. F. G. H. I. J. K. L. ICD Ind 0										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
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. ICD-9 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-0000									
1 07272021 07272021 41 Y A0429 EH A 660.94 1 NPI										AMBULANCE SERVICE - BLS									
2 07272021 07272021 41 Y A0425 EH A 194.75 13.6 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 097A									
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.) ADA County Paramedics 05 09 2023										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28. TOTAL CHARGE \$ 855.69 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use									
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>														
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ICD#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 32 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V					3. PATIENT'S BIRTH DATE MM DD YY 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V							
5. PATIENT'S ADDRESS (No., Street) PO Box 51 CITY STATE ID Boise ID					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) PO Box 51 CITY STATE ID Boise ID							
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>							
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. RESERVED FOR NUCC USE			b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon							
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA HEALTH CARE			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete Items 9, 9a, and 9d.</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. SIGNED SIGNATURE ON FILE DATE 07 19 2021										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 07 27 2021 QUAL 431					15. OTHER 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. <input type="checkbox"/> 17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. R079 B. C. D. E. F. G. H. I. J. K. L. ICD Ind. 0					22. RESUBMISSION CODE ORIGINAL REF. NO.				
23. PRIOR AUTHORIZATION NUMBER 83634					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) GPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPD Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 171A 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
28. TOTAL CHARGE \$ 1405 13					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023					32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309					33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [REDACTED] 9987				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9829</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MORLEY JAMIE L</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1977 M</b>			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>PRISON DOC WOMENS</b>											
5. PATIENT'S ADDRESS (No., Street) <b>13200 S Pleasant Valley Rd 2</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) <b>ATTEN LARRY HEINZ</b>														
CITY <b>Kuna</b>				STATE <b>ID</b>		8. RESERVED FOR NUCC USE				CITY <b>Boise</b>				STATE <b>ID</b>									
ZIP CODE <b>83634</b>				TELEPHONE (Include Area Code) <b>(385) 224-1269</b>				ZIP CODE <b>83707</b>				TELEPHONE (Include Area Code) <b>( )</b>											
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.											
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 <b>SIGNATURE ON FILE</b> DATE <b>07 29 2021</b>												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 <b>SIGNATURE ON FILE</b>											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>07 29 2021</b> QUAL <b>431</b>						15. OTHER 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. <input type="checkbox"/> 17b. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <b>R0602</b> B. C. D. E. F. G. H. I. J. K. L. ICD ind <b>0</b>												22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER <b>83634-2720</b>							
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. EPSON Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID.#					
1 <b>07292021 07292021</b>		<b>41</b>		<b>Y</b>		<b>A0427 EH</b>		<b>A</b>		<b>1377 05</b>		<b>1</b>		<b>NPI</b>									
2 <b>07292021 07292021</b>		<b>41</b>		<b>Y</b>		<b>A0425 EH</b>		<b>A</b>		<b>177 57</b>		<b>12.4</b>		<b>NPI</b>									
3														<b>NPI</b>									
4														<b>NPI</b>									
5														<b>NPI</b>									
6														<b>NPI</b>									
25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>374A</b>				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ <b>1554 62</b>				29. AMOUNT PAID \$ <b>0 00</b>				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.) <b>ADA County Paramedics</b> <b>05 09 2023</b>								32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13200 S Pleasant Valley Rd Kuna, ID 83634-2720</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>								33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>9987</b>							

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9230									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAVEZ REYMUENDO A										3. PATIENT'S BIRTH DATE (MM DD YY) 1977 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) ( )										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) ATTEN VAUGHN CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 333-0037									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER 1607									
b. RESERVED FOR NUCC USE										a. INSURED'S DATE OF BIRTH (MM DD YY) _____ SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
c. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
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 07-29-2021										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d. 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) 07 29 2021 QUAL 431										15. OTHER DATE (MM DD YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ind: 0 A. I79605 B. C. D. E. F. G. H. I. J.										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
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 (CPT/HCPCS) (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
1 07292021 07292021 41 Y A0427 SH A 978 15 1 NPI										AMBULANCE SERVICE - ALS1									
2 07292021 07292021 41 Y A0425 SH A 171 84 12.0 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 410A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1149 99 29. AMOUNT PAID \$ 0 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 hereof.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. 9987 b.									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>	PICA <input type="checkbox"/>										
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (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	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)								
Dade Dana J.	MM DD YY 1963	M <input checked="" type="checkbox"/> F <input type="checkbox"/>	TSCT IDAHO								
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)									
13500 S Pleasant Valley Rd	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	ATTN MEDICAL									
CITY	STATE	CITY	STATE								
Kuna	ID	Boise	ID								
ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)								
83634	( )	83707	(208) 331-1195								
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)	a. INSURED'S DATE OF BIRTH	SEX								
b. RESERVED FOR NUCC USE	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	MM DD YY 1967	M <input checked="" type="checkbox"/> F <input type="checkbox"/>								
c. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
SIGNATURE ON FILE	DATE 07-29-2021	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY 07 29 2021	QUAL 431	FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
17b. NPI	17c.	FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB?	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY									
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Relate A-L to service line below (24E)									
A. R0502	B. I959	C. _____	D. _____								
E. _____	F. _____	G. _____	H. _____								
I. _____	J. _____	K. _____	L. _____								
24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. SPICOT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #		
1 07292021 07292021	41	Y	AMBULANCE SERVICE - ALS1	A0427	EH	AB	1297.48	1	NPI		
2 07292021 07292021	41	Y	MILEAGE	A0425	EH	AB	196.18	13.7	NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX ID. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use					
0277	<input checked="" type="checkbox"/>	439A	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 1493.66	\$ 0.00						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #									
Including degrees or credentials	FROM: 13500 S PLEASANT VALLEY RI	(208) 287-2950									
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Kuna, ID 83634	ADA COUNTY PARAMEDICS									
ADA County Paramedics	TO: 1055 N Curtis Road	370 N. Benjamin Lane									
SIGNED	DATE	Boise, ID 83704-1309	Boise ID 83704-8498								
		9987									



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 23 ID																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BALLARD WESTON L										3. PATIENT'S BIRTH DATE MM DD YY 1982 M X F										4. INSURED'S NAME (Last Name, First Name, Middle Initial) TMST Max Security																			
5. PATIENT'S ADDRESS (No. Street) 13400 S Pleasant Valley Rd Kuna ID 83634										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No. Street) ATTEN DIANNA Boise ID 83707																			
8. RESERVED FOR NUCC USE										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
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 07-30-2021										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 07 30 2021 QUAL 431										15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																			
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD ind: 0 A. I8911 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-2716																			
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 AMBULANCE SERVICE - BLS 07302021 07302021 41 Y A0429 EH A 737 32 1 NPI										2 MILEAGE 07302021 07302021 41 Y A0425 EH A 186 16 13.0 NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 X										26. PATIENT'S ACCOUNT NO. 544A										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 923.48 29. AMOUNT PAID \$ 0.00 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																			
SIGNED										DATE										9987																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
PO Box 981639  
El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 23 ID				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Delgado Eluith S					3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Delgado Eluith S					5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd				
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd				
8. RESERVED FOR NUCC USE					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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)				
11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					b. OTHER CLAIM ID (Designated by NUCC)				
c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # 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.					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 DATE 07-31-2023					SIGNED SIGNATURE ON FILE				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) QUAL 07/31/2021 QUAL 431					15. OTHER DATE (MM/DD/YY)				
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)					17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0					22. RESUBMISSION CODE ORIGINAL REF. NO.				
A. I639 B. C. D. E. F. G. H. I. J. K. L.					23. PRIOR AUTHORIZATION NUMBER 83634				
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/HPCS E. MODIFIER F. DIAGNOSIS POINTER G. \$ CHARGES H. DAYS OR UNITS I. ICD-9 FAMILIAR PLAN ID. QUAL J. RENDERING PROVIDER ID. #									
1. AMBULANCE SERVICE - BLS 07312021 07312021 41 Y A0429 SH A 660.94 1 NPI									
2. MILEAGE 07312021 07312021 41 Y A0425 SH A 189.02 13.2 NPI									
3. NPI									
4. NPI									
5. NPI									
6. NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 713A				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					28. TOTAL CHARGE \$ 849.96				
29. AMOUNT PAID \$ 0.00					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.) ADA County Paramedics 05 09 2023					32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N. Curtis Road Boise, ID 83704-1309				
33. BILLING PROVIDER INFO & PH # (208) 287-2950					33. BILLING PROVIDER INFO & PH # (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>52ID</b>				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Williams Eric L</b>			3. PATIENT'S BIRTH DATE <b>1996</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>IMSI Max Security</b>			7. INSURED'S ADDRESS (No., Street) <b>ATTEN DIANNA</b>			
5. PATIENT'S ADDRESS (No., Street) <b>13400 S Pleasant Valley Rd</b>			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		8. RESERVED FOR NUCC USE			CITY STATE ID <b>Boise ID</b>			
CITY STATE ID <b>Kuna ID</b>			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			
CITY STATE ID <b>Kuna ID</b>			a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
ZIP CODE TELEPHONE (Include Area Code) <b>83634 ( )</b>			b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>			
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO // yes, complete items 9, 9a, and 9d.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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, INJURY or PREGNANCY (LMP) MM DD YY <b>08 04 2021</b> QUAL <b>431</b>			15. OTHER DATE QUAL: 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD ind: <b>0</b>					22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. <b>R609</b> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					23. PRIOR AUTHORIZATION NUMBER <b>83634-2716</b>						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08042021 08042021		41	Y	A0429 EH		A	660 94	1	NPI		
2 08042021 08042021		41	Y	A0425 EH		A	186 16	13.0	NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER <b>0277</b>		SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. <b>465A</b>		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>847 10</b>	29. AMOUNT PAID \$ <b>0 00</b>	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.) <b>ADA County Paramedics</b> <b>05 09 2023</b>			32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>			33. BILLING PROVIDER INFO & PH# <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>9987</b>					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 52ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) NEEP DANNY H		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TJCT IDAHO	
3. PATIENT'S BIRTH DATE MM/DD/YY 1956 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL	
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd Kuna ID 83634 TELEPHONE (Include Area Code) (208) 836-1260		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
8. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY, GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM/DD/YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
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 08-05-2021		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 08/05/2021 QUAL 431		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. QUAL 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0 A. IR079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634	
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. REPORT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 08052021 08052021 41 Y A0427 EH A 1205.18 1 NPI			
2 08052021 08052021 41 Y A0425 EH A 194.75 13.6 NPI			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 567A	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1399.93	
29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics 05 09 2023 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	
		33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medical#) TRICARE <input type="checkbox"/> (ID#/DoD#) GHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BULKUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 14TD																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Knibbe Jordan J										3. PATIENT'S BIRTH DATE (MM DD YY) 1998 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX										4. INSURED'S NAME (Last Name, First Name, Middle Initial) IMST Max Security																																																																															
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY Kuna STATE ID										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA CITY Boise STATE ID																																																																															
8. RESERVED FOR NUCC USE										8. RESERVED FOR NUCC USE										8. RESERVED FOR NUCC USE																																																																															
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH (MM DD YY) M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX																																																																															
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. OTHER CLAIM ID (Designated by NUCC)																																																																															
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.																																																																															
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 05 21 2021																														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 08 06 2021 QUAL 431										15. OTHER DATE QUAL 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. NPI										17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R58 B. C. D. ICD ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 83634																																																																															
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. ICD-9 Family Plan										I. ID. QUAL										J. RENDERING PROVIDER ID. #									
1 08062021 08062021 41 Y										AMBULANCE SERVICE - ALS1										A0427 SH A										978 15 1										NPI																																																											
2 08062021 08062021 41 Y										MILEAGE										A0425 SH A										187 59 13.1										NPI																																																											
3																																																																																																			
4																																																																																																			
5																																																																																																			
6																																																																																																			
25. FEDERAL TAX I.D. NUMBER 0277										SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 726A										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1165 74										29. AMOUNT PAID \$ 0 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.) ADA County Paramedics										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N CURTIS ROAD Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																																																																															
SIGNED DATE 05 09 2023										SIGNED DATE 05 09 2023										SIGNED DATE 05 09 2023										SIGNED DATE 05 09 2023										SIGNED DATE 05 09 2023										SIGNED DATE 05 09 2023																																																	



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 06ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SALINAS PABLO		3. PATIENT'S BIRTH DATE MM DD YY 1966 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 250-2323		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SALINAS PABLO	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 250-2323	
8. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY 1966 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		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 DATE 08-06-2021	
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 08-06-2021		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 08 06 2021 QUAL: 431	
15. OTHER DATE QUAL: 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A. R569 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER 83634		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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 08062021 08062021 41 Y A0427 SH A 1147.90 1 NPI		AMBULANCE SERVICE - ALS1	
2 08062021 08062021 41 Y A0425 SH A 196.18 13.7 NPI		MILEAGE	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 734A	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1344.08	
29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics		32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	
33. BILLING PROVIDER INFO & PH.# (208) 287-2950		33. BILLING PROVIDER INFO & PH.# (208) 287-2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498	
SIGNED DATE 05 09 2023		9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
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 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA B/LK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 32ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Richman Rodney										3. PATIENT'S BIRTH DATE (MM   DD   YY) 1968   M   F SEX: <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Richman Rodney										5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd									
CITY: Kuna STATE: ID										CITY: Kuna STATE: ID									
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 515-0373										ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 515-0373									
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 checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon									
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 08 07 2021										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) 08   07   2021 QUAL 431										15. OTHER DATE (MM   DD   YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM   DD   YY TO MM   DD   YY)									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER 83634																			
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/HCPGS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 08072021 08072021 41 Y A0427 SH A 1148 96 1 NPI										AMBULANCE SERVICE - ALS1									
2 08072021 08072021 41 Y A0425 SH A 189 02 13.2 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 894A									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1337 98									
29. AMOUNT PAID \$ 0 00										30. Hsvd 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH# (208) 287 2950										ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medical#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 501D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Murdoch Keisha D										3. PATIENT'S BIRTH DATE MM/DD/YY 1994 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) ( )										4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (209) 331-1195									
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon										11. INSURED'S DATE OF BIRTH MM/DD/YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
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 08 09 2021										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 08/09/2021 QUAL 431										15. OTHER DATE QUAL MM/DD/YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A. R079 B. C. D. E. F. G. H. I. J. K. L.										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
24. A. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY										22. RESUBMISSION CODE ORIGINAL REF. NO.									
B. PLACE OF SERVICE EMG										23. PRIOR AUTHORIZATION NUMBER 83634-0000									
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS MODIFIER										24. F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 08092021 08092021 41 Y A0427 EH A 1140 47 1 NPI										AMBULANCE SERVICE - ALS1									
2 08092021 08092021 41 Y A0425 EH A 194 75 13.6 NPI										MILEAGE									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 237A									
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.) ADA County Paramedics										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309										28. TOTAL CHARGE \$ 1335 22 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
SIGNED DATE 05 09 2023										33. BILLING PROVIDER INFO & PH.# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																												
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input type="checkbox"/> (ID#)					OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 67ID																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Blake Cody R															3. PATIENT'S BIRTH DATE MM DD YY 1988 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Blake Cody R																													
5. PATIENT'S ADDRESS (No., Street) 8886 W Overland Rd															6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 8886 W Overland Rd																													
CITY Boise					STATE ID					8. RESERVED FOR NUCC USE					CITY Boise					STATE ID																																		
ZIP CODE 83709					TELEPHONE (Include Area Code) (208) 488-8056										ZIP CODE 83709					TELEPHONE (Include Area Code) (208) 488-8056																																		
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					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. AUTO ACCIDENT? PLACE (State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ID					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					10d. CLAIM CODES (Designated by NUCC)					11. INSURED'S DATE OF BIRTH MM DD YY 1988 M <input checked="" type="checkbox"/> F <input type="checkbox"/>														
12. PATIENT'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 DATE 08 10 2021															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 08 10 2021										15. OTHER DATE QUAL 439 MM DD YY 08 10 2021										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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. G8911 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																													
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY										B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSS MODIFIER					E. DIAGNOSIS POINTNER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSOT Family Plan					I. ID. QUAL					J. RENDERING PROVIDER ID. #				
1 08102021 08102021 41 Y										AMBULANCE SERVICE - ALS1					A0427 SH					A					1063 02					1					NPI																			
2 08102021 08102021 41 Y										MILEAGE					A0425 SH					A					42 96					3.0					NPI																			
3																																			NPI																			
4																																								NPI														
5																																								NPI														
6																																								NPI														
25. FEDERAL TAX I.D. NUMBER 0277										SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 306A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 1105 98					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics															32. SERVICE FACILITY LOCATION INFORMATION FROM: N Glenwood St / W Lorimer Garden City, ID 83714 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																													
SIGNED										DATE 05 09 2023					9987					D																																		

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										12. INSURED'S I.D. NUMBER (For Program in Item 1) 39 ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hart Denver J										3. PATIENT'S BIRTH DATE (MM DD YY) SEX 1969 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO										7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE: (208) 331-1195									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State): c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
11. INSURED'S POLICY GROUP OR FECA NUMBER 39										13. INSURED'S DATE OF BIRTH (MM DD YY) SEX 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
12. INSURANCE PLAN NAME OR PROGRAM NAME Centurion of ID IDOC										14. IS THERE ANOTHER HEALTH BENEFIT-PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
15. OTHER DATE (MM DD YY) QUAL: 08 10 2021 431										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: TO: MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO: MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. R079 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 08102021 08102021 41 Y A0427 EH A 1056.65 1 NPI																			
2 08102021 08102021 41 Y A0425 EH A 196.18 13.7 NPI																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 347A									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1252.83 29. AMOUNT PAID \$ 0.00 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medical#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>061D</b>																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Kohoutek Johnathan</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1956 M X F</b>			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Alf Placement Correctional</b>																																									
5. PATIENT'S ADDRESS (No., Street) <b>15505 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) <b>15505 S Pleasant Valley Rd</b>																																												
CITY <b>Kuna</b>		STATE <b>ID</b>		8. RESERVED FOR NUCC USE		CITY <b>Kuna</b>		STATE <b>ID</b>		ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>( )</b>		ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>( )</b>																																					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Kohoutek Johnathan</b>						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER																																									
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>6233</b>						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																									
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)																																									
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>																																									
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>Humana</b>						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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.  SIGNED <b>SIGNATURE ON FILE</b> DATE <b>08-13-2021</b>												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 <b>SIGNATURE ON FILE</b>																																									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>08 13 2021</b> QUAL <b>431</b>						15. OTHER DATE QUAL: 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: <input type="checkbox"/>						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																									
17b: NPI						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: <b>0</b>												22. RESUBMISSION CODE ORIGINAL REF. NO.																																									
A. <b>M79605</b>		B. <b>M25512</b>		C. <input type="checkbox"/>		D. <input type="checkbox"/>		E. <input type="checkbox"/>		F. <input type="checkbox"/>		G. <input type="checkbox"/>		H. <input type="checkbox"/>		I. <input type="checkbox"/>		J. <input type="checkbox"/>																																			
23. PRIOR AUTHORIZATION NUMBER <b>83634</b>						24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE 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		08132021		08132021		41		Y		A0427		SH		AB		1063		02		1		NPI																															
2		08132021		08132021		41		Y		A0425		SH		AB		194		75		13.6		NPI																															
3																						NPI																															
4																						NPI																															
5																						NPI																															
6																						NPI																															
25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. <b>366A</b>						27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ <b>1257.77</b>						29. AMOUNT PAID \$ <b>0.00</b>						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.) <b>ADA County Paramedics</b> 05 09 2023												32. SERVICE FACILITY LOCATION INFORMATION FROM: <b>15505 S. Pleasant Valley Rd Kuna, ID 83634</b> TO: <b>1055 N Curtis Road Boise, ID 83704-1309</b>						33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>																																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>30 ID</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>HASS GREGORY</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>1964</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ISCT IDAHO</b>										5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b>									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b>									
8. RESERVED FOR NUCC USE					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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY <b>1967</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F					b. OTHER CLAIM ID (Designated by NUCC)				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO // yes, complete items 9, 9a, and 9d.				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					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.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										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 DATE <b>08.15.2021</b>										SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>08 15 2021</b> QUAL <b>431</b>										15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b>									
A. <b>R109</b> B. C. D.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
E. F. G. H.										23. PRIOR AUTHORIZATION NUMBER <b>83634</b>									
I. J. K. L.										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 <b>08152021 08152021 41 Y A0427 EH A 978 15 1 NPI</b>										25. FEDERAL TAX I.D. NUMBER SSN EIN <b>0277</b> <input checked="" type="checkbox"/>									
2 <b>08152021 08152021 41 Y A0425 EH A 197 62 13.8 NPI</b>										26. PATIENT'S ACCOUNT NO. <b>044A</b>									
3										27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
4										28. TOTAL CHARGE \$ <b>1175 77</b>									
5										29. AMOUNT PAID \$ <b>0 00</b>									
6										30. Rcvd 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.) <b>ADA County Paramedics</b> <b>05 09 2023</b>										32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>9987</b>									



Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>																																																																															
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BKLUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 65ID																																																																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rogstad Jesse R					3. PATIENT'S BIRTH DATE MM DD YY: 1980 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX																																																																										
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>																																																																										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)																																																																										
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME					4. INSURED'S NAME (Last Name, First Name, Middle Initial) JMST Max Security 7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE: (208) 389-0230 11. INSURED'S POLICY, GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY: SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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. SIGNED SIGNATURE ON FILE DATE 08 16 2021																																																																															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 16 2021 QUAL: 431					15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																																										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ind: 0 A. E876 B. C. D. E. F. G. H. I. J. K. L.					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES: 22. RESUBMISSION CODE ORIGINAL REF. NO.: 23. PRIOR AUTHORIZATION NUMBER: 83634																																																																										
<table border="1"> <thead> <tr> <th>24. A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C. EMG</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>E. DIAGNOSIS POINTER</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. EPSON Family Plan</th> <th>I. ID. QUAL</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>08162021   08162021</td> <td>41</td> <td>Y</td> <td>A0429 SH</td> <td>A</td> <td>660.94</td> <td>1</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>08162021   08162021</td> <td>41</td> <td>Y</td> <td>A0425 SH</td> <td>A</td> <td>186.16</td> <td>13.0</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> </tbody> </table>										24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	08162021   08162021	41	Y	A0429 SH	A	660.94	1		NPI		08162021   08162021	41	Y	A0425 SH	A	186.16	13.0		NPI										NPI										NPI										NPI										NPI	
24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #																																																																						
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08162021   08162021	41	Y	A0425 SH	A	186.16	13.0		NPI																																																																							
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								NPI																																																																							
25. FEDERAL TAX I.D. NUMBER: 0277 <input checked="" type="checkbox"/> SSN EIN: <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO.: 224A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE: \$ 847.10		29. AMOUNT PAID: \$ 0.00		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.) ADA County Paramedics 05 09 2023					32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309																																																																										
33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 SIGNED: DATE: 05 09 2023					30. Rsvd for NUCC Use																																																																										

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA	PICA															
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1494															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FORTNER BRIAN					3. PATIENT'S BIRTH DATE MM DD YY 1994 M X F			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Alt Placement Correctional								
5. PATIENT'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) FORTNER BRIAN					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER 9790								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE			a. INSURED'S DATE OF BIRTH MM DD YY M X F								
b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE			b. OTHER CLAIM ID (Designated by NUCC)								
d. INSURANCE PLAN NAME OR PROGRAM NAME IDHW					10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon								
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 08 16 2021					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 08 16 2021 QUAL: 431					15. OTHER DATE QUAL: 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. R6884 B. C. D. E. F. G. H. I. J. ICD ind: 0					22. RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER B3634								
24. A. DATE(S) OF SERVICE From To MM DD YY 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. EPST Family Pen	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08162021 08162021		41		Y		AMBULANCE SERVICE - BLS A0429 SH A			660 94		1		NPI			
2 08162021 08162021		41		Y		MILEAGE A0425 SH A			194 75		13.6		NPI			
3													NPI			
4													NPI			
5													NPI			
6													NPI			
25. FEDERAL TAX I.D. NUMBER 0277					26. PATIENT'S ACCOUNT NO. 249A			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 855 69		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023					32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309			33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987								

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Cortizon  
PO Box 981639  
El Paso, TX 79998



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare#) <input type="checkbox"/> (Medical ID#) <input type="checkbox"/> (MID/DOB#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Aguilera Raechal M		3. PATIENT'S BIRTH DATE MM + DD + YY 1988		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SICI	
5. PATIENT'S ADDRESS (No. Street) 13900 S Pleasant Valley Rd		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) APTEN VAUGHN		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Kuma		10. IS PATIENT'S CONDITION RELATED TO: 83707		11. INSURED'S POLICY GROUP OR FECA NUMBER (208) 333-0037		12. RESERVED FOR NUCC USE	
13. RESERVED FOR NUCC USE		14. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		15. INSURED'S DATE OF BIRTH MM + DD + YY		16. RESERVED FOR NUCC USE	
17. RESERVED FOR NUCC USE		18. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		19. INSURED'S DATE OF BIRTH MM + DD + YY		20. RESERVED FOR NUCC USE	
19. INSURANCE PLAN NAME OR PROGRAM NAME		20. OTHER CLAIM ID (Designated by NUCC)		21. INSURED'S DATE OF BIRTH MM + DD + YY		22. RESERVED FOR NUCC USE	
23. RESERVED FOR NUCC USE		24. OTHER CLAIM ID (Designated by NUCC)		25. INSURED'S DATE OF BIRTH MM + DD + YY		26. RESERVED FOR NUCC USE	
27. RESERVED FOR NUCC USE		28. OTHER CLAIM ID (Designated by NUCC)		29. INSURED'S DATE OF BIRTH MM + DD + YY		30. RESERVED FOR NUCC USE	
29. RESERVED FOR NUCC USE		30. OTHER CLAIM ID (Designated by NUCC)		31. INSURED'S DATE OF BIRTH MM + DD + YY		32. RESERVED FOR NUCC USE	
33. RESERVED FOR NUCC USE		34. OTHER CLAIM ID (Designated by NUCC)		35. INSURED'S DATE OF BIRTH MM + DD + YY		36. RESERVED FOR NUCC USE	
37. RESERVED FOR NUCC USE		38. OTHER CLAIM ID (Designated by NUCC)		39. INSURED'S DATE OF BIRTH MM + DD + YY		40. RESERVED FOR NUCC USE	
41. RESERVED FOR NUCC USE		42. OTHER CLAIM ID (Designated by NUCC)		43. INSURED'S DATE OF BIRTH MM + DD + YY		44. RESERVED FOR NUCC USE	
45. RESERVED FOR NUCC USE		46. OTHER CLAIM ID (Designated by NUCC)		47. INSURED'S DATE OF BIRTH MM + DD + YY		48. RESERVED FOR NUCC USE	
49. RESERVED FOR NUCC USE		50. OTHER CLAIM ID (Designated by NUCC)		51. INSURED'S DATE OF BIRTH MM + DD + YY		52. RESERVED FOR NUCC USE	
53. RESERVED FOR NUCC USE		54. OTHER CLAIM ID (Designated by NUCC)		55. INSURED'S DATE OF BIRTH MM + DD + YY		56. RESERVED FOR NUCC USE	
57. RESERVED FOR NUCC USE		58. OTHER CLAIM ID (Designated by NUCC)		59. INSURED'S DATE OF BIRTH MM + DD + YY		60. RESERVED FOR NUCC USE	
61. RESERVED FOR NUCC USE		62. OTHER CLAIM ID (Designated by NUCC)		63. INSURED'S DATE OF BIRTH MM + DD + YY		64. RESERVED FOR NUCC USE	
65. RESERVED FOR NUCC USE		66. OTHER CLAIM ID (Designated by NUCC)		67. INSURED'S DATE OF BIRTH MM + DD + YY		68. RESERVED FOR NUCC USE	
69. RESERVED FOR NUCC USE		70. OTHER CLAIM ID (Designated by NUCC)		71. INSURED'S DATE OF BIRTH MM + DD + YY		72. RESERVED FOR NUCC USE	
73. RESERVED FOR NUCC USE		74. OTHER CLAIM ID (Designated by NUCC)		75. INSURED'S DATE OF BIRTH MM + DD + YY		76. RESERVED FOR NUCC USE	
77. RESERVED FOR NUCC USE		78. OTHER CLAIM ID (Designated by NUCC)		79. INSURED'S DATE OF BIRTH MM + DD + YY		80. RESERVED FOR NUCC USE	
81. RESERVED FOR NUCC USE		82. OTHER CLAIM ID (Designated by NUCC)		83. INSURED'S DATE OF BIRTH MM + DD + YY		84. RESERVED FOR NUCC USE	
85. RESERVED FOR NUCC USE		86. OTHER CLAIM ID (Designated by NUCC)		87. INSURED'S DATE OF BIRTH MM + DD + YY		88. RESERVED FOR NUCC USE	
89. RESERVED FOR NUCC USE		90. OTHER CLAIM ID (Designated by NUCC)		91. INSURED'S DATE OF BIRTH MM + DD + YY		92. RESERVED FOR NUCC USE	
93. RESERVED FOR NUCC USE		94. OTHER CLAIM ID (Designated by NUCC)		95. INSURED'S DATE OF BIRTH MM + DD + YY		96. RESERVED FOR NUCC USE	
97. RESERVED FOR NUCC USE		98. OTHER CLAIM ID (Designated by NUCC)		99. INSURED'S DATE OF BIRTH MM + DD + YY		100. RESERVED FOR NUCC USE	





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 351D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hardt Fredrick F										3. PATIENT'S BIRTH DATE MM DD YY 1973 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Hardt Fredrick F										5. PATIENT'S ADDRESS (No., Street) 2758 N Reno Way									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 2758 N Reno Way									
CITY Boise					STATE ID					CITY Boise					STATE ID				
ZIP CODE 83704					TELEPHONE (Include Area Code) (208) 724-1948					ZIP CODE 83704					TELEPHONE (Include Area Code) (208) 724-1948				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Hardt Fredrick F										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER ██████████ 8247										a. INSURED'S DATE OF BIRTH MM DD YY 1973 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME IDHW										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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 08 17 2021										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 08 17 2021 QUAL 431										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ██████████										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. I10 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634									
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. EPSTD Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#																			
1 AMBULANCE SERVICE - BLS 08172021 08172021 41 Y A0429 EH A 660 94 1 NPI																			
2 MILEAGE 08172021 08172021 41 Y A0425 EH A 187 59 13.1 NPI																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 347A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 848 53				
29. AMOUNT PAID \$ 0 00					30. Rsvd for NUCC Use					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287 2950										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 ██████████ 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hunter Kristofer W										3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 1990 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) JISCT IDAHO										5. PATIENT'S ADDRESS (No., Street) 575 E 13th St									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL									
CITY Boise					STATE ID					CITY Boise					STATE ID				
ZIP CODE 83702					TELEPHONE (Include Area Code) (986) 837-1623					ZIP CODE 83707					TELEPHONE (Include Area Code) (208) 331-1195				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Hunter Kristofer W										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER 8194										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME Division of Medicaid										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
12. PATIENT'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 DATE 08-17-2021										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 08/17/2021 QUAL 431										15. OTHER DATE MM/DD/YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R079 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 83634									
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) GPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1. 08172021 08172021 41 Y A0427 EH A 1140.47 1 NPI										AMBULANCE SERVICE - ALS1									
2. 08172021 08172021 41 Y A0425 EH A 171.84 12.0 NPI										MILEAGE									
3. NPI																			
4. NPI																			
5. NPI																			
6. NPI																			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 447A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1312.31 29. AMOUNT PAID \$ 0.00 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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287 2950										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

PLCA

PATIENT AND INSURED INFORMATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

1. MEDICARE (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DOD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (Health Plan) <input type="checkbox"/> (BLNG) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> OTHER		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rogstad Jesse R		3. PATIENT'S BIRTH DATE 1980 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TIMMY MAX SECURITY		5. PATIENT'S ADDRESS (No. Street) 13400 S Pleasant Valley Rd		6. PATIENT RELATIONSHIP TO INSURED Sell <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) TIMMY MAX SECURITY		8. RESERVED FOR NUCC USE	
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 83707		12. RESERVED FOR NUCC USE		13. RESERVED FOR NUCC USE		14. RESERVED FOR NUCC USE		15. RESERVED FOR NUCC USE		16. RESERVED FOR NUCC USE			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		19. RESERVED FOR NUCC USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		22. RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE	
25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 847.10		29. AMOUNT PAID \$ 0.00		30. HAS FOR NUCC USE		31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # (208) 287 2950		34. FROM: 14601 S PLEASANT VALLEY RD ADA COUNTY PARAMEDICS		35. TO: 1055 N CURTIS ROAD Boise, ID 83704-1309		36. DATE 05 09 2023		37. SIGNED		38. DATE 08 18 2021		39. SIGNED		40. DATE 08 18 2021	

APPROVED OMB-0938-1197 FORM 1500 (02-12)



Corizon  
 PO Box 981639  
 El Paso, TX 79998

<input type="checkbox"/>		X		14ID	
Knibbe Jordan J		1998 <input checked="" type="checkbox"/> <input type="checkbox"/>		TMST Max Security	
13400 S Pleasant Valley Rd		X		ATTEN DIANNA	
Kuna ID		Boise ID			
83634		83707		(208) 389-0230	
		X		X	
		<input checked="" type="checkbox"/> NO			
		X		Corizon	
				X	
SIGNATURE ON FILE		08 19 2021		SIGNATURE ON FILE	
08 19 2021 431					
R52		0		N	
				83634-2716	
08192021		08192021		41 Y A0427 EH A 1071 51 1	
				AMBULANCE SERVICE - ALS1	
08192021		08192021		41 Y A0425 EH A 186 16 13.0	
				MILEAGE	
				NPI	
				NPI	
				NPI	
0277		X		655A X	
				1257 67 0 00	
				208 287 2950	
ADA County Paramedics		FROM: 13400 S Pleasant Valley Rd		ADA COUNTY PARAMEDICS	
05 09 2023		Kuna, ID 83634-2716		370 N. Benjamin Lane	
		TO: 1055 N Curtis Road		Boise ID 83704-8498	
		Boise, ID 83704-1309		9987	



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**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 99ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CLEMENTS TYSON D										3. PATIENT'S BIRTH DATE MM DD YY 1995 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX									
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY Kuna STATE ID										4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCT IDAHO									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL									
8. RESERVED FOR NUCC USE										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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
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 08 19 2021										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 08 19 2021 QUAL 431										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. I S0990XA B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER 83634										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To 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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From To 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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 08192021 08192021 41 Y A0427 EH A 1068.32 1 NPI										1 08192021 08192021 41 Y A0427 EH A 1068.32 1 NPI									
2 08192021 08192021 41 Y A0425 EH A 196.18 13.7 NPI										2 08192021 08192021 41 Y A0425 EH A 196.18 13.7 NPI									
3										3									
4										4									
5										5									
6										6									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 678A									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 1264.50 29. AMOUNT PAID \$ 0.00 30. Rev'd 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.) ADA County Paramedics 05 09 2023 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N. Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH # (208) 287-2950										33. BILLING PROVIDER INFO & PH # (208) 287-2950									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA																																		
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input type="checkbox"/> (ID#)					OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 991D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mora Peter T															3. PATIENT'S BIRTH DATE MM DD YY 1968 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID-CorrecCenter																			
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd City: Kuna ID: 83634															6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTEN: MEDICAL City: Boise ID: 83707																			
8. RESERVED FOR NUCC USE															9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER ██████████ 1607									
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 08-19-2021															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 08 19 2021 QUAL 431										15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. LK922 B. C. D. ICD Ind. 0 E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 83634																								
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #																								
1 08192021 08192021		41		Y		AMBULANCE SERVICE - BLS A0429 EH A				650 94		1		NPI																														
2 08192021 08192021		41		Y		MILEAGE A0425 EH A				199 05		13 9		NPI																														
3														NPI																														
4														NPI																														
5														NPI																														
6														NPI																														
25. FEDERAL TAX I.D. NUMBER ██████████ 0277										26. PATIENT'S ACCOUNT NO. ██████████ 727A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 859.99					29. AMOUNT PAID \$ 0.00					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.) ADA County Paramedics SIGNED DATE 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 190 E Bannock Street Boise, ID 83712-6241										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 ██████████ 9987																								

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PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 601D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Aguilera Raechal M										3. PATIENT'S BIRTH DATE MM DD YY 1988 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd Kuna ID 83634 TELEPHONE (Include Area Code) (208) 414-2121										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SICI										7. INSURED'S ADDRESS (No., Street) ATTEN VAUGHN Boise ID 83707 TELEPHONE (Include Area Code) (208) 333-0037									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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 08 20 2021										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 08 20 2021 QUAL 431										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 9rd 0 A. R569 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-0000									
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. EPSO1 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#																			
1. 08202021 08202021 41 Y A0427 EH A 1222 16 1 NPI																			
2. 08202021 08202021 41 Y A0425 EH A 196 18 13 7 NPI																			
3. NPI																			
4. NPI																			
5. NPI																			
6. NPI																			
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 893A 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
29. TOTAL CHARGE \$ 1418 34										29. AMOUNT PAID \$ 0 00									
30. Rsvd for NUCC Use										33. BILLING PROVIDER INFO & PH.# (208) 287 2950									
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.) ADA County Paramedics 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise ID 83704-1309									
34. BILLING PROVIDER INFO & PH.# ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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<input type="checkbox"/>		<input checked="" type="checkbox"/>		09 ID						
PIERCE ROBERT W		1970 <input checked="" type="checkbox"/>		ICC ID CorrecCenter						
14601 S Pleasant Valley Rd		<input checked="" type="checkbox"/>		ATTEN MEDICAL						
Kuna ID		Boise ID								
83634-2709		83707		(208) 331-2760						
		1607								
		X								
		X								
		<input checked="" type="checkbox"/>		Corizon						
				<input checked="" type="checkbox"/>						
SIGNATURE ON FILE		02-22-2021		SIGNATURE ON FILE						
08 21 2021		431								
A R0603		0								
E										
J				83634						
		AMBULANCE SERVICE - BLS								
08212021	08212021	41	Y	A0429	EH	A	660 94	1		
		MILEAGE								
08212021	08212021	41	Y	A0425	EH	A	189 02	13.2		NPI
										NPI
										NPI
0277 <input checked="" type="checkbox"/>		1956A <input checked="" type="checkbox"/>		849 96		0 00		208 287 2950		
ADA County Paramedics		FROM: 13500 S PLEASANT VALLEY RD		ADA COUNTY PARAMEDICS		370 N. Benjamin Lane				
05 09 2023		TO: 1055 N Curtis Road		Boise ID 83704-8498						
		Boise, ID 83704-1309		9987						

PHYSICIAN OR SUPPLIER INFORMATION





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**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 13 ID																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Campbell Jerry W						3. PATIENT'S BIRTH DATE MM DD YY 1945 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Campbell Jerry W																						
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 338-1635						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 338-1635																						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) JSCI IDAHO						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 1945 M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																						
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 08 22 2021						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 08 22 2021 QUAL 431				15. OTHER DATE QUAL: MM DD YY 17a. 17b. NPI				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES:		22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER 83634															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I R109 B. C. D. ICD (nd) 0 E. F. G. H. I. J. K. L.												24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG MM DD YY MM DD YY				B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. ICD-9-CM Family Per		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1												AMBULANCE SERVICE - ALS1				1281.56		1		NPI											
2												MILEAGE				196.18		13.7		NPI											
3																				NPI											
4																				NPI											
5																				NPI											
6																				NPI											
25. FEDERAL TAX I.D. NUMBER 0277				SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 162A				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 1477.74		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH# ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medical#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 52ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>AMLTN CHAMBRAY R</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>1991</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>STCT</b>									
5. PATIENT'S ADDRESS (No., Street) <b>2621 Sparrow</b> CITY: <b>Caldwell</b> STATE: <b>ID</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) <b>ATTEN VAUGHN</b> CITY: <b>Boise</b> STATE: <b>ID</b>									
8. ZIP CODE: <b>83605</b> TELEPHONE (Include Area Code): <b>(208) 453-1380</b>					6. RESERVED FOR NUCC USE					7. ZIP CODE: <b>83707</b> TELEPHONE (Include Area Code): <b>(208) 333-0037</b>									
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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: <b>SIGNATURE ON FILE</b> DATE: <b>08-24-2021</b>										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: <b>SIGNATURE ON FILE</b>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>08 24 2021</b> QUAL: <b>431</b>					15. OTHER DATE QUAL:					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. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: MM DD YY TO: MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. <b>IR079</b> B. C. D. ICD Ind: <b>0</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#										23. PRIOR AUTHORIZATION NUMBER <b>83634-0000</b>									
1. <b>08242021 08242021 41 Y A0427 EH A 1140.47 1 NPI</b> <b>AMBULANCE SERVICE - ALS1</b>																			
2. <b>08242021 08242021 41 Y A0425 EH A 206.21 14.4</b> <b>MILEAGE</b>																			
3.																			
4.																			
5.																			
6.																			
25. FEDERAL TAX I.D. NUMBER: <b>0277</b> SSN EIN: <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO.: <b>502A</b>					27. ACCEPT ASSIGNMENT? (For govt claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
28. TOTAL CHARGE: \$ <b>1346.68</b>					29. AMOUNT PAID: \$ <b>0.00</b>					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.) <b>ADA County Paramedics</b> SIGNED: <b>05 09 2023</b> DATE:										32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000</b> <b>TO: 190 E Bannock Street Boise, ID 83712-6241</b>					33. BILLING PROVIDER INFO & PH# <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane Boise ID 83704-8498</b> <b>(208) 287-2950</b>				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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				X	58ID				
WISE CHAD L		1969		<input checked="" type="checkbox"/>	Alt Placement Correctional				
15505 S Pleasant Valley Rd				X	15505 S Pleasant Valley Rd				
Kuna		ID			Kuna		ID		
83634					83634				
WISE CHAD L									
58				X					
				X					
				X	Corizon				
Centurion of ID IDOC					X				
SIGNATURE ON FILE				08 25 2021	SIGNATURE ON FILE				
08 25 2021		431							
R079				0					
					83634				
08252021		08252021		41	Y	A0427	SH	A	1145 77 1
08252021		08252021		41	Y	A0425	SH	A	194 75 13.6
									NPI
									NPI
0277		X		649A	X		1340 52	0 00	208 287 2950
ADA County Paramedics		05 09 2023		FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634		ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498			
				TO: 1055 N Curtis Road Boise, ID 83704-1309		9987			



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**HEALTH INSURANCE CLAIM FORM**

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

CARRIER

1. MEDICARE (Medicare#) <input type="checkbox"/>	MEDICAID (Medicaid#) <input type="checkbox"/>	TRIGARE (ID#/DoD#) <input type="checkbox"/>	CHAMPVA (Member ID#) <input type="checkbox"/>	GROUP HEALTH PLAN (ID#) <input type="checkbox"/>	FECA BLK/LUNG (ID#) <input checked="" type="checkbox"/>	OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 961D		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Litzenberg Marklin W			3. PATIENT'S BIRTH DATE MM DD YY 1984 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO	
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 836-0740			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Litzenberg Marklin W			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 8739				
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME UNITED HEALTH CARE		10d. CLAIM CODES (Designated by NUCC)				
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 08 26 2021			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 08 26 2021 QUAL 431			15. OTHER DATE QUAL 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. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			22. RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0			23. PRIOR AUTHORIZATION NUMBER 83634			24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#			
1 08262021 08262021 41 Y A0427 EH A 978.15 1 NPI			AMBULANCE SERVICE - ALS1						
2 08262021 08262021 41 Y A0425 EH A 196.18 13.7 NPI			MILEAGE						
3			NPI						
4			NPI						
5			NPI						
6			NPI						
25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 826A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 1174.33	29. AMOUNT PAID \$ 0.00	30. Pts/d 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.) ADA County Paramedics 05 09 2023			32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309			33. BILLING PROVIDER INFO & PH.# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Corizon  
PO Box 981639  
El Paso, TX 79998

CARRIER

PICA		PICA	
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 931D	
2. PATIENT'S NAME (Last Name; First Name, Middle Initial) Shelly Carl D		4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter	
3. PATIENT'S BIRTH DATE (MM DD YY) 1979 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX		7. INSURED'S ADDRESS (No., Street) ATTEN: MEDICAL	
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name; First Name, Middle Initial)	
CITY: Kuna STATE: ID		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
CITY: Boise STATE: ID		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 376-4597		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER		10d. CLAIM CODES (Designated by NUCC)	
83707 (208) 331-2760		11. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name; First Name, Middle Initial)		b. OTHER CLAIM ID (Designated by NUCC)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
b. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
c. RESERVED FOR NUCC USE		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
12. PATIENT'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 DATE 08 27 2021	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) 08 27 2021 QUAL 431		15. OTHER DATE (MM DD YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	
17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E). ICD Ind 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. IM25572 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634	
24. A. DATE(S) OF SERVICE From To 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. ICD-10 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 945A 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
1. 08272021 08272021 41 Y A0429 SH A 660 94 1 NPI		28. TOTAL CHARGE \$ 849 96 29. AMOUNT PAID \$ 0 00 30. Ref'd for NUCC Use	
2. 08272021 08272021 41 Y A0425 SH A 189 02 13 2 NPI		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.) ADA County Paramedics	
3. NPI		32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634	
4. NPI		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498	
5. NPI		SIGNED DATE 05 09 2023 TO: 1055 N Curtis Road Boise, ID 83704-1309	
6. NPI		9987	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medical#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 55TD	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Wildman Thomas				3. PATIENT'S BIRTH DATE MM DD YY 1981 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID Correction					
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) (541) 216-3616				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) ATEN MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Corizon					
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 02-28-2021				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 08 27 2021 QUAL 431					
15. OTHER DATE QUAL 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 _____					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I479604 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					
22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER B1634		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					
1. 08272021 08272021 41 Y A0429 EH A 660 94 1 NPI				2. 08272021 08272021 41 Y A0425 EH A 189 02 13 2 NPI		3. _____ 4. _____ 5. _____ 6. _____					
25. FEDERAL TAX I.D. NUMBER 0277		26. PATIENT'S ACCOUNT NO. 982A		27. ACCEPT ASSIGNMENT? (For gov. claims see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. TOTAL CHARGE \$ 849 96		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics SIGNED DATE 05 09 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 201D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Johnson, Crystal M										3. PATIENT'S BIRTH DATE (MM DD YY) SEX 1990 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd Kuna, ID 83634 TELEPHONE (Include Area Code) (208) 360-2894										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
8. RESERVED FOR NUCC USE										7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL Boise, ID 83707 TELEPHONE (Include Area Code) (208) 331-1195									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH (MM DD YY) SEX 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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] DATE: 08-27-2021										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] DATE: 08-27-2021									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 08-27-2021 QUAL: 431										15. OTHER DATE QUAL: MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R1030 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#										23. PRIOR AUTHORIZATION NUMBER 83634									
1. 08272021 08272021 41 Y A0427 SH A 986.64 1 NPI										2. 08272021 08272021 41 Y A0425 SH A 194.75 13.6 NPI									
3.										4.									
5.										6.									
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 990A									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1181.39									
29. AMOUNT PAID \$ 0.00										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.) ADA County Paramedics SIGNED: [Signature] DATE: 05 09 2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
33. BILLING PROVIDER INFO & PH# (208) 287 2950										ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 871D			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Beckett David W						3. PATIENT'S BIRTH DATE MM DD YY 1961 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Beckett David W								
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd						6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd								
CITY Kuna			STATE ID			8. RESERVED FOR NUCC USE						CITY Kuna			STATE ID		
ZIP CODE 83634			TELEPHONE (Include Area Code) ( )									ZIP CODE 83634			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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY 1961 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					

PATIENT AND INSURED INFORMATION

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 08 30 2021

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 08 30 2021 QUAL 431		15. OTHER DATE QUAL 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. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 117

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R52 B. C. D. ICD Ind. 0				22. RESUBMISSION CODE ORIGINAL REF. NO.	
E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER 83634	

	24. A. DATE(S) OF SERVICE		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 #
	From MM DD YY	To MM DD YY										
1	08302021	08302021	41	Y	A0427	EH	A	1140.47	1		NPI	
2	08302021	08302021	41	Y	A0425	EH	A	197.62	13.8		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 0277		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 395A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1338.09		29. AMOUNT PAID \$ 0.00		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.) ADA County Paramedics						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise ID 83704-1309			33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987				

SIGNED \_\_\_\_\_ DATE 05 09 2023





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA BLK LUNG <input type="checkbox"/> (ID#)            OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) ██████████ 65 ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MARKS RICKIE I</b>				3. PATIENT'S BIRTH DATE MM DD YY    SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> ██████████ 1957		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>MARKS RICKIE I</b>					
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b> CITY: Kuna    STATE: ID    ZIP CODE: 83634    TELEPHONE: ( )				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b> CITY: Kuna    STATE: ID    ZIP CODE: 83634    TELEPHONE: ( )					
8. RESERVED FOR NUCC USE				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State): c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
11. INSURED'S POLICY GROUP OR FECA NUMBER				12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.		11. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> ██████████ 1957					
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: 08-30-2021				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: 431 08 30 2021				15. OTHER DATE QUAL: 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES:				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0		22. RESUBMISSION CODE    ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER <b>83634</b>				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    E. DIAGNOSIS POINTER    F. \$ CHARGES    G. DAYS OR UNITS    H. EFSBT Pansy Plan    I. ID. QUAL    J. RENDERING PROVIDER ID.#					
1    AMBULANCE SERVICE - BLS 08302021    08302021    41    Y    A0429    EH    A    660.94    NPI				2    MILEAGE 08302021    08302021    41    Y    A0425    EH    A    189.02    13.2    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 gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. TOTAL CHARGE \$ 849.96    29. AMOUNT PAID \$ 0.00    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.) <b>ADA County Paramedics</b> SIGNED:    DATE: 05 09 2023		32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>					
33. BILLING PROVIDER INFO. & PH.# (208) 287 2950 <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> SIGNED:    DATE: 9987											



Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)					521D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
Williams Eric J					MM DD YY 1996 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					IMSI Max Security									
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED					7. INSURED'S ADDRESS (No., Street)									
13400 S Pleasant Valley Rd					Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					ATTEN DIANNA									
CITY					STATE					CITY					STATE				
Kuna					ID					Boise					ID				
ZIP CODE					TELEPHONE (Include Area Code)					ZIP CODE					TELEPHONE (Include Area Code)				
83634					( )					83707					(208) 389-0230				
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)					a. INSURED'S DATE OF BIRTH					SEX				
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					MM DD YY					M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT?					b. OTHER CLAIM ID (Designated by NUCC)									
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME									
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					Corizon									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10c. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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 SIGNATURE ON FILE DATE 08 31 2021										SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)					15. OTHER DATE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY 08 31 2021 QUAL 431					QUAL MM DD YY					FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a.					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
					17b. NPI					FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
										<input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICS5 B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
										83634									
24. A. DATE(S) OF SERVICE					B. PLACE OF SERVICE					C. D. PROCEDURES, SERVICES, OR SUPPLIES					E. DIAGNOSIS POINTER				
From To MM DD YY MM DD YY					EMG					(Explain Unusual Circumstances) CPT/HCPCS MODIFIER									
1 08312021 08312021 41 Y					V					A0427 SH A					1145 77 1 NPI				
2 08312021 08312021 41 Y					V					A0425 SH A					186 16 13 0 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?				
0277					<input type="checkbox"/> X					598A					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE					29. AMOUNT PAID					30. Pldvd for NUCC Use									
\$ 1331 93					\$ 0 00														
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									
ADA County Paramedics										FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634									
05 09 2023										TO: 1055 N Curtis Road Boise, ID 83704-1309									
SIGNED DATE										33. BILLING PROVIDER INFO & PH #									
										(208) 287 2950									
										ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 991D									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mora Peter T										3. PATIENT'S BIRTH DATE MM DD YY 1968 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter										5. INSURED'S DATE OF BIRTH MM DD YY 1607 M <input type="checkbox"/> F <input type="checkbox"/>									
6. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 886-9588										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760										8. RESERVED FOR NUCC USE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER 1607									
b. RESERVED FOR NUCC USE										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
c. RESERVED FOR NUCC USE										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 DATE 09 02 2021									
d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 02 2021 QUAL 431									
15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0 A. IR0602 B. C. D. E. F. G. H. I. J. K. L.									
22. RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER 83634									
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. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#										25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 867A 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
1. 09022021 09022021 41 Y A0427 EH A 1140 47 1 NPI										28. TOTAL CHARGE \$ 1329 49 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
2. 09022021 09022021 41 Y A0425 EH A 189 02 13 2 NPI										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.) ADA County Paramedics 05 09 2023 SIGNED DATE									
3. NPI										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309									
4. NPI										33. BILLING PROVIDER INFO & PH# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987									
5. NPI																			
6. NPI																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																		
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					OHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input checked="" type="checkbox"/> (ID#)					OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>4429</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Maki Tawny L</b>															3. PATIENT'S BIRTH DATE MM DD YY <b>1991</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>PRISON DOC WOMENS</b>																			
5. PATIENT'S ADDRESS (No., Street) <b>733 W Ramsbrook St</b>															6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) <b>ATTEN LARRY HEINZ</b>																			
CITY <b>Boise</b>					STATE <b>ID</b>					6. RESERVED FOR NUCC USE					CITY <b>Boise</b>					STATE <b>ID</b>					ZIP CODE <b>83702</b>					TELEPHONE (Include Area Code) <b>( )</b>					ZIP CODE <b>83707</b>					TELEPHONE (Include Area Code) <b>( )</b>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Maki Tawny L</b>															10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY, GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b> d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>8961</b>					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME <b>IDHW</b>					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 <b>SIGNATURE ON FILE</b> DATE <b>09-03-2021</b>																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL <b>09 03 2021 431</b>															15. OTHER DATE QUAL 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. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <b>I959</b> B. C. D. E. F. G. H. I. J. K. L.															ICD Ind. <b>0</b>										23. PRIOR AUTHORIZATION NUMBER <b>83634-0000</b>																			
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 POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPST Family Pen		I. ID. QUAL		J. RENDERING PROVIDER ID. #																								
1. <b>09032021 09032021</b>			<b>41</b>		<b>Y</b>		<b>A0427 EH</b>			<b>A</b>		<b>978 15</b>		<b>1</b>		<b>NPI</b>		<b></b>		<b></b>																								
2. <b>09032021 09032021</b>			<b>41</b>		<b>Y</b>		<b>A0425 EH</b>			<b>A</b>		<b>194 75</b>		<b>13.6</b>		<b>NPI</b>		<b></b>		<b></b>																								
3. <b></b>			<b></b>		<b></b>		<b></b>			<b></b>		<b></b>		<b></b>		<b>NPI</b>		<b></b>		<b></b>																								
4. <b></b>			<b></b>		<b></b>		<b></b>			<b></b>		<b></b>		<b></b>		<b>NPI</b>		<b></b>		<b></b>																								
5. <b></b>			<b></b>		<b></b>		<b></b>			<b></b>		<b></b>		<b></b>		<b>NPI</b>		<b></b>		<b></b>																								
6. <b></b>			<b></b>		<b></b>		<b></b>			<b></b>		<b></b>		<b></b>		<b>NPI</b>		<b></b>		<b></b>																								
25. FEDERAL TAX I.D. NUMBER <b>0277</b>					SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>007A</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>1172 90</b>					29. AMOUNT PAID \$ <b>0 00</b>					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.) <b>ADA County Paramedics</b> 05 09 2023															32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>										33. BILLING PROVIDER INFO & PH # <b>(208) 287 2950</b> <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
PO Box 981639  
El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE (Medicare#) <input type="checkbox"/>	MEDICAID (Medicaid#) <input type="checkbox"/>	TRICARE (ID#/DoD#) <input type="checkbox"/>	CHAMPVA (Member ID#) <input type="checkbox"/>	GROUP HEALTH PLAN (ID#) <input type="checkbox"/>	FECA BLK LUNG (ID#) <input checked="" type="checkbox"/>	OTHER (ID#) <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>661D</b>		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Gunn Michael J</b>			3. PATIENT'S BIRTH DATE (MM   DD   YY) <b>1965</b>		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TSCI IDAHO</b>			
5. PATIENT'S ADDRESS (No., Street) <b>1201 Garfield St</b>			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b>				
CITY <b>Boise</b>	STATE <b>ID</b>	8. RESERVED FOR NUCC USE	CITY <b>Boise</b>	STATE <b>ID</b>	7. INSURED'S ADDRESS (No., Street) (continued)				
ZIP CODE <b>83706-0000</b>	TELEPHONE (Include Area Code) <b>(626) 626-3603</b>	8. RESERVED FOR NUCC USE	ZIP CODE <b>83707</b>	TELEPHONE (Include Area Code) <b>(208) 331-1195</b>	8. RESERVED FOR NUCC USE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Gunn Michael J</b>			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>2687</b>	b. RESERVED FOR NUCC USE	c. RESERVED FOR NUCC USE	a. INSURED'S DATE OF BIRTH (MM   DD   YY) <b>1967</b>	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	b. OTHER CLAIM ID (Designated by NUCC)				
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>Veterans Office of Community Care</b>			10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>				
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 <b>SIGNATURE ON FILE</b> DATE <b>09-05-2021</b>			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM   DD   YY QUAL <b>09   05   2021 QUAL 431</b>			15. OTHER DATE QUAL 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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A <b>1R4182</b> B <b>1Z8616</b> C _____ D _____ E _____ F _____ G _____ H _____ I _____ J _____ K _____ L _____ ICD Ind: <b>0</b>			23. PRIOR AUTHORIZATION NUMBER <b>83634</b>		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) OPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. FSDOT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09052021 09052021 41 Y	AMBULANCE SERVICE - ALS1	A0427	EH	AB	1377.05	1	NPI		
2 09052021 09052021 41 Y	MILEAGE	A0425	EH	AB	191.89	13.4	NPI		
3							NPI		
4							NPI		
5							NPI		
6							NPI		
25. FEDERAL TAX I.D. NUMBER <b>0277</b>		SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. <b>303A</b>	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ <b>1568.94</b>	29. AMOUNT PAID \$ <b>0.00</b>	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.) <b>ADA County Paramedics</b> 05 09 2023			32. SERVICE FACILITY LOCATION INFORMATION FROM: <b>13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> TO: <b>1055 N Curtis Road Boise, ID 83704-1309</b>		33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medical#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
--------------------------------------------------	----------------------------------------------	---------------------------------------------	-----------------------------------------------	--------------------------------------------------	----------------------------------------------	-------------------------------------------------	---------------------------------------------------

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Escamilla Teddy G</b>	3. PATIENT'S BIRTH DATE MM DD YY <b>1959</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TSCT IDAHO</b>
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5. PATIENT'S ADDRESS (No., Street) <b>13500 S Pleasant Valley Rd</b>	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) <b>ATTN MEDICAL</b>
-------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------

CITY <b>Kuna</b>	STATE <b>ID</b>	8. RESERVED FOR NUCC USE	CITY <b>Boise</b>	STATE <b>ID</b>
ZIP CODE <b>83634</b>	TELEPHONE (Include Area Code) <b>( )</b>		ZIP CODE <b>83707</b>	TELEPHONE (Include Area Code) <b>(208) 331-1195</b>

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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH MM DD YY <b>1967</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>
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b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. OTHER CLAIM ID (Designated by NUCC)
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c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>
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d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
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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 <b>09 05 2021</b>		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	
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14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>09 05 2021</b> QUAL <b>431</b>	15. OTHER DATE QUAL <b>431</b>	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service-line below (24E). ICD Ind. <b>0</b>	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. <b>G8911</b> B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER <b>83634</b>

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PERSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1. 09052021 09052021	41	Y	A0427 EH	A	978.15	1		NPI	
2. 09052021 09052021	41	Y	A0425 EH	A	191.89	13.4		NPI	
3.								NPI	
4.								NPI	
5.								NPI	
6.								NPI	

25. FEDERAL TAX I.D. NUMBER <b>0277</b>	SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. <b>316A</b>	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ <b>1170.04</b>	29. AMOUNT PAID \$ <b>0.00</b>	30. Rsvd for NUCC Use
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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.) <b>ADA County Paramedics</b>	32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>	33. BILLING PROVIDER INFO & PH # <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>
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CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 96ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) STEWART AARON R						3. PATIENT'S BIRTH DATE MM DD YY 1988 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCT IDAHO						
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE: (208) 331-1195						
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		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10d. CLAIM CODES (Designated by NUCC)	
a. INSURED'S DATE OF BIRTH MM DD YY 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									

PATIENT AND INSURED INFORMATION

**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: 09-07-2021

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 09 07 2021 431		15. OTHER DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service-line below (24E) ICD ICD 0				22. RESUBMISSION CODE ORIGINAL REF. NO.	
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23. PRIOR AUTHORIZATION NUMBER 83634	
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24. A. DATE(S) OF SERVICE	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. EPST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
09072021 - 09072021	41	Y	A0427 EH	A	1216.85	1		NPI	
09072021 - 09072021	41	Y	A0425 EH	A	196.18	13.7		NPI	
								NPI	
								NPI	
								NPI	
								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 0277		SSN EIN: <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO.: 627A		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE: \$ 1413.03		29. AMOUNT PAID: \$ 0.00		30. Rsvd for NUCC Use	
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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.) ADA County Paramedics 05 09 2023				32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987			
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Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA										PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 73ID					4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID: CorrecCenter					7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LARSON JUSTIN T					3. PATIENT'S BIRTH DATE (MM/DD/YY) 1991 M <input checked="" type="checkbox"/> F <input type="checkbox"/> SEX					4. INSURED'S ADDRESS (No., Street) Boise ID					7. INSURED'S ADDRESS (No., Street) Boise ID				
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd Kuna ID					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					8. RESERVED FOR NUCC USE					8. RESERVED FOR NUCC USE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME Corizon				
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: 09-08-2021										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) 09/08/2021 QUAL: 431					15. OTHER DATE (MM/DD/YY)					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES					22. RESUBMISSION CODE ORIGINAL REF. NO.				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										23. PRIOR AUTHORIZATION NUMBER 83634									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD (incl. 0) A. U071 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										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 (ICD) F. \$ CHARGES G. DAYS OR UNITS H. ERSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1. 09082021 09082021 41 Y A0429 EH A 725.65 1 NPI										2. 09082021 09082021 41 Y A0425 EH A 189.02 13.2 NPI									
3. _____ NPI										4. _____ NPI									
5. _____ NPI										6. _____ NPI									
25. FEDERAL TAX I.D. NUMBER 0277 SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 751A					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					28. TOTAL CHARGE \$ 914.67				
29. AMOUNT PAID \$ 0.00					30. Flsd 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.) ADA County Paramedics 05 09 2023					32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309				
33. BILLING PROVIDER INFO & PH# (208) 287-2950					33. BILLING PROVIDER INFO & PH# (208) 287-2950					33. BILLING PROVIDER INFO & PH# (208) 287-2950					33. BILLING PROVIDER INFO & PH# (208) 287-2950				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>52ID</b>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MORTON FRED</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1973 M X F</b>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Alt Placement Correctional</b>								
5. PATIENT'S ADDRESS (No., Street) <b>15501 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) <b>15505 S Pleasant Valley Rd</b>					
CITY <b>Kuna</b>			STATE <b>ID</b>			8. RESERVED FOR NUCC USE			CITY <b>Kuna</b>			STATE <b>ID</b>					
ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>						ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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.  SIGNED: <b>SIGNATURE ON FILE</b> DATE: <b>09-08-2021</b>												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: <b>SIGNATURE ON FILE</b>					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>09 08 2021</b> QUAL <b>431</b>				15. OTHER DATE QUAL <b>431</b>				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. <input type="checkbox"/>				17b. NPI				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												22. RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E). A. <b>R079</b> B. C. D. E. F. G. H. I. J. K. L. ICD (nd) <b>0</b>												23. PRIOR AUTHORIZATION NUMBER <b>83634</b>					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. REPORT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1. <b>09082021 09082021</b>		<b>41 Y</b>		<b>A0429 SH</b>		<b>A</b>		<b>660.94</b>		<b>1</b>		<b>NPI</b>					
2. <b>09082021 09082021</b>		<b>41 Y</b>		<b>A0425 SH</b>		<b>A</b>		<b>196.18</b>		<b>13.7</b>		<b>NPI</b>					
3.												<b>NPI</b>					
4.												<b>NPI</b>					
5.												<b>NPI</b>					
6.												<b>NPI</b>					
25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>780A</b>				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ <b>857.12</b>		29. AMOUNT PAID \$ <b>0.00</b>		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.) <b>ADA County Paramedics</b> 05 09 2023						32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 15505 S. Pleasant Valley Rd Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>						33. BILLING PROVIDER INFO & FH # <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA  PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>091D</b>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Borowiak Clifford</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1981</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Borowiak Clifford</b>																
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>													
CITY <b>Kuna</b>			STATE <b>ID</b>			8. RESERVED FOR NUCC USE			CITY <b>Kuna</b>			STATE <b>ID</b>													
ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>			ZIP CODE <b>83634</b>			TELEPHONE (Include Area Code) <b>( )</b>			11. INSURED'S POLICY GROUP OR FECA NUMBER													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ICC ID CorrecCenter</b>						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S DATE OF BIRTH MM DD YY <b>1981</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)													
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>09</b>						d. INSURANCE PLAN NAME OR PROGRAM NAME <b>Centurion of ID IDOC</b>						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>													
b. RESERVED FOR NUCC USE						10d. CLAIM CODES (Designated by NUCC)						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
c. RESERVED FOR NUCC USE						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 _____													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>09 10 2021</b> QUAL <b>431</b>						15. OTHER 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. QUAL						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
17b. NPI						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E)) A. <b>R52</b> B. C. D. E. F. G. H. I. J. K. L.						ICD Ind <b>0</b>						22. RESUBMISSION CODE ORIGINAL REF. NO.													
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. ICD Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1		09102021		09102021		41 Y		A0429 EH				A		660 94		1		NPI							
2		09102021		09102021		41 Y		A0425 EH				A		187 59		13.1		NPI							
3																		NPI							
4																		NPI							
5																		NPI							
6																		NPI							
25. FEDERAL TAX I.D. NUMBER <b>0277</b>						26. PATIENT'S ACCOUNT NO. <b>999A</b>						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO													
28. TOTAL CHARGE <b>\$ 848 53</b>						29. AMOUNT PAID <b>\$ 0 00</b>						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.) <b>ADA County Paramedics</b>						32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b>						33. BILLING PROVIDER INFO & PH# <b>ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498</b>													
SIGNED _____ DATE <b>05 09 2023</b>						TO: <b>1055 N. Curtis Road Boise, ID 83704-1309</b>						b. <b>9987</b>													

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																							
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input type="checkbox"/> (ID#)					OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 57ID														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hibbard Randy J.															3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] 1984 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) JSCJ TDAH0																													
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd															6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL																													
CITY Kuna					STATE ID					8. RESERVED FOR NUCC USE					CITY Boise					STATE ID																													
ZIP CODE 83634					TELEPHONE (Include Area Code) (208) 616-6144										ZIP CODE 83707					TELEPHONE (Include Area Code) (208) 331-1195																													
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					SEX					b. OTHER CLAIM ID (Designated by NUCC)																													
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																													
c. RESERVED FOR NUCC USE					10d. CLAIM CODES (Designated by NUCC)																																												
d. INSURANCE PLAN NAME OR PROGRAM NAME																																																	
<p align="center"><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> <p>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.</p> <p>SIGNED SIGNATURE ON FILE DATE 03 05 2021</p>																									<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED SIGNATURE ON FILE</p>																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 09 10 2021 431										15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. IR0602 B. Z8616 C. D. ICD ICD 0 E. F. G. H. I. J. K. L.																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY					B. PLACE OF SERVICE EMG					C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTNER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL					J. RENDERING PROVIDER ID. #									
1. 09102021 09102021 41 Y					AMBULANCE SERVICE - BLS					A0429 EH AB					725 65					1					NPI																								
2. 09102021 09102021 41 Y					MILEAGE					A0425 EH AB					193 32					13.5					NPI																								
3.																									NPI																								
4.																														NPI																			
5.																																			NPI														
6.																																								NPI									
25. FEDERAL TAX I.D. NUMBER [REDACTED] 0277										SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. [REDACTED] 017A					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 918 97					29. AMOUNT PAID \$ 0 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.) ADA County Paramedics															32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH# ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [REDACTED] 9987																								

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE (Medicare#) <input type="checkbox"/>		MEDICAID (Medicaid#) <input type="checkbox"/>		TRICARE (ID#/DoD#) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (ID#) <input type="checkbox"/>		FECA BLK LUNG (ID#) <input checked="" type="checkbox"/>		OTHER (ID#) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 911D			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Bennett Steven J						3. PATIENT'S BIRTH DATE MM DD YY 1970 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) TCG ID CorrecCenter								
5. PATIENT'S ADDRESS (No., Street) 14601 Pleasant Valley Road CITY Kuna STATE ID ZIP CODE 83634 TELEPHONE (Include Area Code) (325) 514-1303						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL CITY Boise STATE ID ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Bennett Steven J						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.								
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 09 10 2021						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 09 10 2021 QUAL 431						15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) _____								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). A. R1030 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						22. RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER 83634								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTS		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 09102021 09102021		41 Y		A0427 EH		A		986 64		1		NPI					
2 09102021 09102021		41 Y		A0425 EH		A		189 02		13.2		NPI					
3												NPI					
4												NPI					
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER 0277				SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 029A				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1175 66		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics 05 09 2023						32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309						33. BILLING PROVIDER INFO & PH # ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION







Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA  PICA

1. MEDICARE  (Medicare#) MEDICAID  (Medicaid#) TRICARE  (ID#/DoD#) CHAMPVA  (Member ID#) GROUP HEALTH PLAN  (ID#) FECA BLX LUNG  (ID#) OTHER  (ID#) 1a. INSURED'S I.D. NUMBER (For Program in Item 1) **57ID**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Hibbard Randy L** 3. PATIENT'S BIRTH DATE (MM/DD/YY) **1984** SEX  M  F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) **ISCI IDAHO**

5. PATIENT'S ADDRESS (No., Street) **13500 S Pleasant Valley Rd** 6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other  7. INSURED'S ADDRESS (No., Street) **ATTN MEDICAL**

CITY STATE ID CITY STATE ID  
**Kuna ID** **Boise ID**

ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code)  
**83634 (208) 616-6144** **83707 (208) 331-1195**

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 b. AUTO ACCIDENT?  YES  NO PLACE (State) c. OTHER ACCIDENT?  YES  NO

b. RESERVED FOR NUCC USE c. INSURANCE PLAN NAME OR PROGRAM NAME **Corizon**

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.

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 SIGNATURE ON FILE DATE **09 11 2021** SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
 MM DD YY QUAL 17a. 17b. NPI 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES  
 YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E). ICD ind: **0** 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. **R0602** B. **Z8616** C. D. E. F. G. H. I. J. K. L. 23. PRIOR AUTHORIZATION NUMBER **83634**

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. FOST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #

1 **09112021 09112021 41 Y A0427 EH AB 1042 86 1 NPI**

2 **09112021 09112021 41 Y A0425 EH AB 197 62 13.8 NPI**

3

4

5

6

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 \$ **1240 48** 29. AMOUNT PAID \$ **0 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.) **ADA County Paramedics** 32. SERVICE FACILITY LOCATION INFORMATION **FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309** 33. BILLING PROVIDER INFO & PH# **ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498**

SIGNED DATE **05 09 2023** **9987**



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 PO Box 981639  
 El Paso, TX 79998

<input type="checkbox"/>		X		79ID	
Fuller Christopher L		[REDACTED] 1971 <input checked="" type="checkbox"/>		ICC ID CorrecCenter	
14601 S Pleasant Valley Rd		X		ATTEN MEDICAL	
Kuna	ID	Boise	ID		
83634		83707		(208) 331-2760	
		X			
		X NO			
		X		Corizon	
				X	
SIGNATURE ON FILE			SIGNATURE ON FILE		
09 11 2021 431			09 11 2021		
A: IT8140XA		B:		0	
E:		F:		83634	
L:		J:			
AMBULANCE SERVICE - ALS1					
09112021	09112021	41	Y	A0427	SH A 983 45 1
MILEAGE					
09112021	09112021	41	Y	A0425	SH A 187 59 13.1
NPI					
NPI					
NPI					
NPI					
NPI					
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
[REDACTED] 0277		<input type="checkbox"/> <input checked="" type="checkbox"/>		[REDACTED] 237A	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE	
(I certify that the statements on the reverse apply to this bill and are made a part hereof.)		(For gov. claims see back)		\$ 1171 04	
ADA County Paramedics		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		29. AMOUNT PAID \$ 0 00	
05 09 2023		32. SERVICE FACILITY LOCATION INFORMATION		30. Rsvd for NUCC Use	
SIGNED		FROM: 14601 S PLEASANT VALLEY RI		33. BILLING PROVIDER INFO & PH# (208) 287 2950	
DATE		Kuna, ID 83634		ADA COUNTY PARAMEDICS	
		TO: 1055 N Curtis Road		370 N. Benjamin Lane	
		Boise, ID 83704-1309		Boise ID 83704-8498	
				[REDACTED] 9987	

PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

		X		99ID	
RICHARDSON MICHAEL B		1984 <input checked="" type="checkbox"/>		IMST Max Security	
14601 S Pleasant Valley Rd		X		ATTEN DIANNA	
Kuna	ID			Boise	ID
83634	208 605-0799			83707	(208) 389-0230
		X		X	
		X			
		X		Corizon	
				X	
SIGNATURE ON FILE			09 14 2021		SIGNATURE ON FILE
09 14 2021		431			
R4182				0	
				83634-2716	
AMBULANCE SERVICE - ALS1					
09142021	09142021	41	Y	A0427	EH A 978 15 1
MILEAGE					
09142021	09142021	41	Y	A0425	EH A 164 68 11.5
NPI					
NPI					
NPI					
NPI					
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small>
0277		<input checked="" type="checkbox"/>	680A		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
\$ 1142 83		\$ 0 00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>			32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#
ADA County Paramedics			FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716		(208) 287 2950
SIGNED: 05 09 2023			TO: 1055 N Curtis Road Boise, ID 83704-1309		ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
DATE			9987		b



Corizon  
 PO Box 981639  
 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>451D</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MUNOZ PEDRO</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>1955 M X F</b>			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>TCC ID CorrecCenter</b>									
5. PATIENT'S ADDRESS (No., Street) <b>14601 S Pleasant Valley Rd</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) <b>ATTEN MEDICAL</b>			8. RESERVED FOR NUCC USE									
CITY <b>Kuna</b>		STATE <b>ID</b>		ZIP CODE <b>83634</b>		TELEPHONE (Include Area Code) <b>( )</b>		CITY <b>Boise</b>		STATE <b>ID</b>		ZIP CODE <b>83707</b>		TELEPHONE (Include Area Code) <b>(208) 331-2760</b>							
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Corizon</b>									
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</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. SIGNED <b>SIGNATURE ON FILE</b> DATE <b>09-15-2021</b>												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 <b>SIGNATURE ON FILE</b>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <b>09 15 2021</b> QUAL <b>431</b>						15. OTHER DATE QUAL 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. NPI		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ind. <b>0</b>												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. <b>R079</b> B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER <b>83634</b>									
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. EPSON Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 <b>09152021 09152021</b>		<b>41</b>		<b>Y</b>		<b>A0427 EH</b>				<b>A</b>		<b>1140 47</b>		<b>1</b>		<b>NPI</b>					
2 <b>09152021 09152021</b>		<b>41</b>		<b>Y</b>		<b>A0425 EH</b>				<b>A</b>		<b>189 02</b>		<b>13.2</b>		<b>NPI</b>					
3																<b>NPI</b>					
4																<b>NPI</b>					
5																<b>NPI</b>					
6																<b>NPI</b>					
25. FEDERAL TAX I.D. NUMBER <b>0277</b> SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>833A</b>				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ <b>1329 49</b>		29. AMOUNT PAID \$ <b>0.00</b>		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.) <b>ADA County Paramedics</b>						32. SERVICE FACILITY LOCATION INFORMATION <b>FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634</b> <b>TO: 1055 N Curtis Road Boise, ID 83704-1309</b>						33. BILLING PROVIDER INFO & PH# <b>ADA COUNTY PARAMEDICS</b> <b>370 N. Benjamin Lane</b> <b>Boise ID 83704-8498</b> <b>9987</b>									

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
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 El Paso, TX 79998

**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 93ID									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Van Natta Theodore J										3. PATIENT'S BIRTH DATE MM DD YY 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SICT				
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) ATTEN VAUGHN CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 333-0037				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State): ID c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>					b. OTHER CLAIM ID (Designated by NUCC)				
b. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				
c. RESERVED FOR NUCC USE										10d. CLAIM CODES (Designated by NUCC)					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 DATE 09 16 2021				
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 09 16 2021										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 09 16 2021 431										15. OTHER DATE QUAL MM DD YY 439 09 16 2021					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. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER 83634				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I8911 B. C. D. E. F. G. H. I. J. K. L. ICD ICD 0										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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
1 09162021 09162021 41 Y A0427 SH A 995.13 1 NPI										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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					28. TOTAL CHARGE \$ 1187.02 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use				
2 09162021 09162021 41 Y A0425 SH A 191.89 13.4 NPI										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. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					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.) ADA County Paramedics 05 09 2023				
3 4 5 6										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13950 S Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309					33. BILLING PROVIDER INFO & FH.# (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION





Corizon  
 PO Box 981639  
 El Paso, TX 79998

<input type="checkbox"/>		X		08ID	
Deardorff William D		1955 <input checked="" type="checkbox"/> <input type="checkbox"/>		STCI	
13900 S Pleasant Valley Rd		X		ATTEN VAUGHN	
Kuna ID		Boise ID			
83634		83707		(208) 333-0037	
		X		X	
		X			
		X		Corizon	
				X	
SIGNATURE ON FILE			09-17-2021		
09 17 2021 431			SIGNATURE ON FILE		
M545		R001		0	
				83634-0000	
09172021		09172021 41 Y		AMBULANCE SERVICE - ALS1	
		A0427 EH AB		1140 47 1	
09172021		09172021 41 Y		MILEAGE	
		A0425 EH AB		196 18 13.7	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
0277		<input type="checkbox"/> <input checked="" type="checkbox"/>		090A	
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		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	
ADA County Paramedics		FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
05 09 2023		TO: 1055 N Curtis Road Boise, ID 83704-1309		28. TOTAL CHARGE \$ 1336 65	
SIGNED		DATE		29. AMOUNT PAID \$ 0 00	
				30. Rsvd for NUCC Use	
				(208) 287 2950	
				33. BILLING PROVIDER INFO & PH #	
				ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498	
				9987	





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<input type="checkbox"/>		X	99ID
Mora Peter T	1968	<input checked="" type="checkbox"/>	TCC ID CorrecCenter
14601 S Pleasant Valley Rd		X	ATTEN MEDICAL
Kuna	ID		Boise ID
83634	208 386-9588		83707 (208) 331-2760
			1607
		X	
		X	
		X	Corizon
			X

SIGNATURE ON FILE 09 17 2021 SIGNATURE ON FILE

09 17 2021	431		

A IR509	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

AMBULANCE SERVICE - ALS1											
09172021	09172021	41	Y	A0427	EH	A	978	15	1		
MILEAGE											
09172021	09172021	41	Y	A0425	EH	A	189	02	13.2		
											NPI
											NPI
											NPI
											NPI

25. FEDERAL TAX ID NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small>	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
0277	<input type="checkbox"/> <input checked="" type="checkbox"/>	116A	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 1167.17	\$ 0.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#		
ADA County Paramedics		FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634		(208) 287 2950		
SIGNED		TO: 1055 N. Curtis Road		ADA COUNTY PARAMEDICS		
DATE		Boise, ID 83704-1309		370 N. Benjamin Lane		
05 09 2023				Boise, ID 83704-8498		
				9987		





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**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program In Item 1) 65ID																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Arnold Ferrell D										3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 1977 M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO																			
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE: ( )										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ATTN: MEDICAL CITY: Boise STATE: ID ZIP CODE: 83707 TELEPHONE: (208) 331-1195																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State): c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon																			
12. PATIENT'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 DATE 09.19.2021										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 09/19/2021 QUAL 431										15. OTHER DATE (MM/DD/YY) QUAL										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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. Z9109 B. C. D. E. F. G. H. I. J. K. L.										24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG B. C. 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. 09/19/2021 09/19/2021 41 Y A0433 EH A 1198.82 1 NPI										2. 09/19/2021 09/19/2021 41 Y A0425 EH A 193.32 13.5 NPI										3. NPI																			
4. NPI										5. NPI										6. NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 0277 <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 437A										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$ 1392.14 29. AMOUNT PAID \$ 0.00 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.) ADA County Paramedics 05/09/2023										32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309										33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498																			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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<input type="checkbox"/>		X		21ID	
Hernandez Valdez Lupe		1975 X		ICC ID CorrecCenter	
14601 S Pleasant Valley Rd		X		ATTEN MEDICAL	
Kuna ID		Boise ID			
83634		83707		(208) 331-2760	
		X			
		X			
		<input checked="" type="checkbox"/>		Corizon	
				X	
SIGNATURE ON FILE		09 19 2021		SIGNATURE ON FILE	
09 19 2021 431					
R0602		0		83634	
09192021		09192021		41 Y	
A0427		SH		A	
1205 18		1			
09192021		09192021		41 Y	
A0425		SH		A	
189 02		13.2		NPI	
				NPI	
				NPI	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
0277		<input type="checkbox"/> X		483A	
				27. ACCEPT ASSIGNMENT?	
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28. TOTAL CHARGE	
				\$ 1394 20	
				29. AMOUNT PAID	
				\$ 0 00	
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		30. Rsvd for NUCC Use	
ADA County Paramedics		FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634		(208) 287 2950	
05 09 2023		TO: 1055 N Curtis Road		ADA COUNTY PARAMEDICS	
SIGNED		Boise, ID 83704-1309		370 N. Benjamin Lane	
DATE				Boise ID 83704-8498	
				9987	







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 El Paso, TX 79998

<input type="checkbox"/>		<input checked="" type="checkbox"/>		63ID	
Wolf Lee T		1953 <input checked="" type="checkbox"/>		TSCI IDAHO	
13500 S Pleasant Valley Rd		<input checked="" type="checkbox"/>		ATTN MEDICAL	
Kuna ID		Boise ID			
83634		83707		(208) 331-1195	
Wolf Lee T					
51		<input checked="" type="checkbox"/>		1967 <input checked="" type="checkbox"/>	
		<input checked="" type="checkbox"/> NO			
		<input checked="" type="checkbox"/>		Corizon	
Centurion of ID IDOC				<input checked="" type="checkbox"/>	
SIGNATURE ON FILE		09 21 2021		SIGNATURE ON FILE	
09 21 2021 431				N	
R079		0		a	
				83634	
AMBULANCE SERVICE - ALS1					
09212021	09212021	41	Y	A0427	EH A 1205 18 1
MILEAGE					
09212021	09212021	41	Y	A0425	EH A 196 18 13.7 NPI
NPI					
NPI					
NPI					
NPI					
NPI					
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?	
0277 <input type="checkbox"/> <input checked="" type="checkbox"/>		756A <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 1401.36 29. AMOUNT PAID \$ 0.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION		30. Rsvd for NUCC Use	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) ADA County Paramedics 05 09 2023 SIGNED DATE		FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987	



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 PO Box 981639  
 El Paso, TX 79998

<input type="checkbox"/>		X		09ID	
BURNINGHAM ROWE L		1964 <input checked="" type="checkbox"/>		SICI	
13900 S Pleasant Valley Rd		X		ATTEN VAUGHN	
Kuna	ID			Boise	ID
83634	208 965-1760			83707	(208) 333-0037
		X		X	
		X			
		X		Corizon	
				X	
SIGNATURE ON FILE			09-23-2021		
09 23 2021 431			SIGNATURE ON FILE		
0					
T50904A				83634-0000	
09232021		09232021 41 Y		AMBULANCE SERVICE - ALS1	
		A0427 EH		A 1140.47 1	
		MILEAGE			
09232021		09232021 41 Y		A0425 EH	
		A		196.18 13.7	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
0277		<input type="checkbox"/> <input checked="" type="checkbox"/>		182A	
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
\$ 1336.65		\$ 0.00			
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#	
ADA County Paramedics		FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000		(208) 287 2950	
05 09 2023		TO: 1055 N Curtis Road		ADA COUNTY PARAMEDICS	
SIGNED		Boise, ID 83704-1309		370 N. Benjamin Lane	
DATE				Boise ID 83704-8498	
				9987	





Corizon  
 PO Box 981639  
 El Paso, TX 79998

# HEALTH INSURANCE CLAIM FORM

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

PICA \_\_\_\_\_ PICA \_\_\_\_\_

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BY LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Berkheimer Jack L						3. PATIENT'S BIRTH DATE MM DD YY 1935 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO	
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	8. RESERVED FOR NUCC USE	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL			
CITY Kuna		STATE ID	TELEPHONE (Include Area Code) (208) 336-0740	CITY Boise	STATE ID	TELEPHONE (Include Area Code) (208) 331-1195		ZIP CODE 83707
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) TSCI IDAHO			10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER 53	b. RESERVED FOR NUCC USE	c. RESERVED FOR NUCC USE	d. INSURANCE PLAN NAME OR PROGRAM NAME Centurion of ID IDOC	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. CLAIM CODES (Designated by NUCC)	10d. CLAIM CODES (Designated by NUCC)
a. INSURED'S DATE OF BIRTH MM DD YY 1967 M X F	b. OTHER CLAIM ID (Designated by NUCC)	c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.	12. PATIENT'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 DATE 09-23-2021				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 23 2021 QUAL 431	15. OTHER DATE QUAL	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	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. I079	B.	C.	D.	E.	F.	G.	H.	I.
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 POINTNER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL
1. 09232021 09232021 41 Y A0427 EH A 1140.47 1 NPI	2. 09232021 09232021 41 Y A0425 EH A 197.62 13.8 NPI	3.	4.	5.	6.	7.	8.	9.
25. FEDERAL TAX I.D. NUMBER 0277	SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 195A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 1338.09	29. AMOUNT PAID \$ 0.00	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.) ADA County Paramedics	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH# ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 9987						
SIGNED	DATE 05 09 2023	SIGNED	DATE 09 23 2021	SIGNED	DATE 09 23 2021	SIGNED	DATE 09 23 2021	SIGNED

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



Corizon  
 PO Box 981639  
 El Paso, TX 79998

<input type="checkbox"/>		X		311D	
Moreno, Jose		1999 <input checked="" type="checkbox"/>		ICC ID: CorrecCenter	
14601 S Pleasant Valley Rd		<input checked="" type="checkbox"/>		ATTEN: MEDICAL	
Kuna ID		Boise ID			
83634		208 331-2760		83707 (208) 331-2760	
		X			
		X			
		<input checked="" type="checkbox"/>		Corizon	
				<input checked="" type="checkbox"/>	
SIGNATURE ON FILE			09 24 2021		
09 24 2021 431					
S0181XA			0		
			B3634		
09242021 09242021 41 Y A0427 SH A 986 64 1			AMBULANCE SERVICE - ALS1		
09242021 09242021 41 Y A0425 SH A 189 02 13 2			MILEAGE		
			NPI		
			NPI		
			NPI		
			NPI		
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
0277		<input checked="" type="checkbox"/>		324A	
		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID	
(For gov. claims: see back)		\$ 1175 66		\$ 0 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#	
INCLUDING DEGREES OR CREDENTIALS		FROM: 14601 S PLEASANT VALLEY RD		(208) 287 2950	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		Kuna, ID 83634		ADA COUNTY PARAMEDICS	
ADA County Paramedics		TO: 1055 N Curtis Road		370 N. Benjamin Lane	
05 09 2023		Boise, ID 83704-1309		Boise ID 83704-8498	
SIGNED		DATE		9987	



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<input type="checkbox"/>		X		65ID	
Arnold Ferrell D		1977 <input checked="" type="checkbox"/>		ISCI IDAHO	
13500 S Pleasant Valley Rd		X		ATTN MEDICAL	
Kuna ID		Boise ID			
83634		83707		(208) 331-1195	
		X		1967 X	
		X NO			
		X		Corizon	
				X	
SIGNATURE ON FILE		09-25-2021		SIGNATURE ON FILE	
09-25-2021 431					
A: T782XXA		B: _____		0	
E: _____		F: _____		83634	
J: _____					
09252021		09252021 41 Y		AMBULANCE SERVICE - ALS2	
		A0433 EH		A 1489 50	
09252021		09252021 41 Y		MILEAGE	
		A0425 EH		A 186 16 13 0	
				NPI	
				NPI	
				NPI	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
0277		<input checked="" type="checkbox"/>		507A	
27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID	
For govt. claims, see back		\$ 1675 66		\$ 0 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION		30. Rsvd for NUCC Use	
INCLUDING DEGREES OR CREDENTIALS.		FROM: 13500 S PLEASANT VALLEY RD		(208) 287 2950	
(I certify that the statements on the reverse		Kuna, ID 83634		ADA COUNTY PARAMEDICS	
apply to this bill and are made a part thereof.)		TO: 1055 N Curtis Road		370 N. Benjamin Lane	
ADA County Paramedics		Boise, ID 83704-1309		Boise ID 83704-8498	
05 09 2023		SIGNED		9987	
DATE					

PHYSICIAN OR SUPPLIER INFORMATION



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<input type="checkbox"/>		<input checked="" type="checkbox"/>		28ID	
LAVATTA BRIAN J		1989 <input checked="" type="checkbox"/>		LAVATTA BRIAN J	
13400 S Pleasant Valley Rd		<input checked="" type="checkbox"/>		13400 S Pleasant Valley Rd	
Kuna ID		Kuna ID		83634	
83634		83634		83634	
		<input checked="" type="checkbox"/>		1989 <input checked="" type="checkbox"/>	
		<input checked="" type="checkbox"/>		Corizon	
		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
09 27 2021 431					
R0602		0		83634	
09272021 09272021 41 Y		AMBULANCE SERVICE - ALS1		1140 47 1	
09272021 09272021 41 Y		MILEAGE		161 82 11 3 NPI	
				NPI	
				NPI	
				NPI	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?	
0277 <input checked="" type="checkbox"/>		680A <input checked="" type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
\$ 1302 29		\$ 0 00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.) ADA County Paramedics 05 09 2023 SIGNED: _____ DATE: _____		FROM: 14601 S PLEASANT VALLEY RD Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a) 9987 b)	





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				X		70ID					
DOYLE JOSHUA T				1991		DOYLE JOSHUA T					
14601 S Pleasant Valley Rd				X		14601 S Pleasant Valley Rd					
Kuna		ID		Kuna		ID					
83634				83634							
				X		1991					
				X							
				X		Corizon					
						X					
09 27 2021		431									
M549						0					
						83634					
09272021		09272021		41 Y		A0427 EH A					
						978 15 1					
09272021		09272021		41 Y		A0425 EH A					
						189 02 13 2					
						NPI					
						NPI					
						NPI					
						NPI					
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?					
0277		X		749A		YES NO					
28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use							
\$ 1167 17		\$ 0 00									
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.) ADA County Paramedics				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH #			
05 09 2023				DATE				(208) 287 2950			
SIGNED				DATE				Boise, ID 83704-1309			
				Boise, ID 83704-1309				Boise ID 83704-8498			



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**HEALTH INSURANCE CLAIM FORM**

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

<input type="checkbox"/> MEDICARE <input type="checkbox"/> (Medicare#)	<input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#)	<input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DoD#)	<input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#)	<input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	<input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#)	<input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED] 72ID				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Tilford Alan P			3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] 1959 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) TMSI Max Security			7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA			
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd CITY: Kuna STATE: ID ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		8. RESERVED FOR NUCC USE			11. INSURED'S POLICY-GROUP OR FECA NUMBER Boise ID 83707 TELEPHONE (Include Area Code): (208) 389-0230			
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			12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>			b. OTHER CLAIM ID (Designated by NUCC)			
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State):		b. OTHER CLAIM ID (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon			
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
d. INSURANCE PLAN NAME OR PROGRAM NAME			(0d. CLAIM CODES (Designated by NUCC))		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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.					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 DATE 09 27 2021					SIGNED SIGNATURE ON FILE						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 27 2021 QUAL 431			15. OTHER DATE QUAL: 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. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0					22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. I 959 B. C. D. E. F. G. H. I. J. K. L.					23. PRIOR AUTHORIZATION NUMBER 83634-2716						
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. EPOSD Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09272021 09272021 41 Y		41 Y	Y	A0427 EH		A	1157 47	1	NPI	NPI	
2 09272021 09272021 41 Y		41 Y	Y	A0425 EH		A	187 59	13.1	NPI	NPI	
3		41 Y	Y	A0425 EH		A	187 59	13.1	NPI	NPI	
4		41 Y	Y	A0425 EH		A	187 59	13.1	NPI	NPI	
5		41 Y	Y	A0425 EH		A	187 59	13.1	NPI	NPI	
6		41 Y	Y	A0425 EH		A	187 59	13.1	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER 0277		26. PATIENT'S ACCOUNT NO. [REDACTED] 828A	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 1345 06		29. AMOUNT PAID \$ 0 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.) ADA County Paramedics		
32. SERVICE FACILITY LOCATION INFORMATION FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498		34. 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.) ADA County Paramedics		35. DATE 05 09 2023		36. TO: 1055 N Curtis Road Boise, ID 83704-1309		37. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. [REDACTED] 9987	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION