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[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): TXX98442113900

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

3. PATIENT'S BIRTH DATE MM DD YY: 09/04/1949 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 881 S Lorraine apt 212

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 881 S Lorraine apt 212

CITY: Wheaton STATE: IL

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY: Wheaton STATE: IL

ZIP CODE: 60187 TELEPHONE (Include Area Code): (630)221-0624

ZIP CODE: 60187 TELEPHONE (INCLUDE AREA CODE): (630)221-0624

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 09/04/1949 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: TJMaxx

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

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 _____ 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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. Dojna Barr

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

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

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. Major Depression 296.34
2. PTSD 309.81
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08/07/2006	08/07/2008	11		90806		309.81	120.00					
2 08/14/2006	08/14/2006	11		90806		309.81	120.00					
3 08/21/2006	08/21/2006	11		90808		296.34	120.00					
4 08/25/2006	08/25/2006	11		90806		296.34	120.00					
5 09/05/2006	09/05/2006	11		90806		296.34	120.00					
6 09/11/2006	09/11/2006	11		90806		296.34	120.00					

25. FEDERAL TAX I.D. NUMBER: 131-60-4391 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 720.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 720.00

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.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Liliana Popovic MA MS LCPC
1825 College Ave#230
Wheaton IL

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Liliana Popovic MA MS LCPC
POBOX 1666, tel 630 854-9164
Warrenville IL 60555

PIN# lic# 18004195 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG, FECA AND EEOICPA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung, FECA and EEOICPA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional services by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, Black Lung and EEOICPA programs. Authority to collect information is in sections 205(a), 1862, 1872 and 1874 of the Social Security Act, as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq. and 10 USC 1079 and 1086; 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Departments of Veterans Affairs, Health and Human Services and/or Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services received or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State law.

Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)

GENERAL INFORMATION—FECA AND EEOICPA CLAIMANTS: Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for occupational illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or occupational illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

FEES: The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

REPORTS: A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

GENERAL INFORMATION—BLBA CLAIMANTS: The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

OWCP is authorized (5 USC 8101 et seq.; 30 USC 901 et seq.; 42 USC 7384d) to collect information needed to administer FECA, BLBA and EEOICPA. The information collected is used to identify the eligibility of the claimant for benefits, and to determine coverage of services provided. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information.

SIGNATURE OF PHYSICIAN OR SUPPLIER: Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered or were rendered incident to your direct order. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FORM SUBMISSION

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742, unless otherwise instructed.
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828, unless otherwise instructed.
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 727, Lanham-Seabrook, MD 20703-0727, unless otherwise instructed.

INSTRUCTIONS FOR COMPLETING THE FORM: A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

Item 1.	Leave blank.
Item 1a.	Enter the patient's claim number.
Item 2.	Enter the patient's last name, first name, middle initial.
Item 3.	Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
Item 4.	For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
Item 5.	Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
Item 6.	Leave blank.
Item 7.	For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
Item 8.	Leave blank.
Item 9.	Leave blank.
Item 10.	Leave blank.
Item 11.	For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.
Item 11a.	Leave blank.
Item 11b.	Leave blank.
Item 11c.	Leave blank.
Item 11d.	Leave blank.
Item 12.	The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.
Item 13.	Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.
Item 14.	Leave blank.
Item 15.	Leave blank.
Item 16.	Leave blank.
Item 17.	Leave blank.
Item 18.	Leave blank.
Item 19.	Leave blank.
Item 20.	Leave blank.

Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.

Item 22. Leave blank.

Item 23. Leave blank.

Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).
Column C: not required.
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.
Column F: enter the total charge(s) for each listed service(s).
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.
Column H: leave blank.
Column I: leave blank.
Column J: leave blank.
Column K: leave blank.

Item 25: Enter the Federal tax I.D.

Item 26: Provider may enter a patient account number that will appear on the remittance voucher.

Item 27: Leave blank.

Item 28: Enter the total charge for the listed services in Column F.

Item 29: If any payment has been made, enter that amount here.

Item 30: Enter the balance now due.

Item 31: Sign and date the form. Signature stamp or "signature on file" is acceptable.

Item 32: Enter complete name of hospital, facility or physician's office were services were rendered.

Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0055. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0055), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

Place of Service (POS) Codes for Item 24B

3	School
4	Homeless Shelter
5	Indian Health Service Free-Standing Facility
6	Indian Health Service Provider-Based Facility
7	Tribal 638 Free-Standing Facility
8	Tribal 638 Provider-Based Facility
11	Office
12	Patient Home
15	Mobile Unit
20	Urgent Care
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center (CMHC)
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service