Outpatient Claim Form (Sample - Filled)

Date of Submission: 2024-06-17

1. Patient Information

Patient Name	John Doe	**Date of Birth**	1980-03-14
Insurance ID	INS-12345678	**Policy Number**	PL-78901234
Contact Number	(555) 234-5678	**Email Address**	johndoe@email.com

2. Provider/Facility Information

Provider Name	Sunrise Medical Clinic	**Physician**	Dr. Emily Spencer
Provider Address	123 Wellness Avenue, Springfield, XY 45678		
NPI Number	101010100	**Contact**	(555) 123-6789

3. Diagnosis Details

Primary Diagnosis Code	J20.9	**Primary Diagnosis Description**	Acute bronchitis, unspecified
Secondary Diagnosis Code	J45.909	**Secondary Diagnosis Description**	Unspecified asthma, uncomplicated
Clinical Findings	• Patient presents with dry cough, mild fever, and wheezing. • No prior history of chronic lung disease. • Auscultation reveals expiratory rhonchi. • Pulse oximetry: 97% on room air.		

4. Services Rendered

Date	Service Provided	CPT/HCPCS Code	Amount Billed
2024-06-15	Evaluation & Management (Office Visit)	99213	$120.00
2024-06-15	Chest X-ray	71045	$85.00
2024-06-15	Nebulizer Treatment	94640	$45.00

5. Additional Information

Referring Physician	Dr. Lisa Carter	**Referral Date**	2024-06-13
Attachments	Lab test results, Prescription copy, Referral note		

6. Declaration & Signature

Patient/Guardian Declaration: I certify that the above information is true and complete.
Signature: _____
Date: 2024-06-17

Provider Declaration: I hereby attest that services rendered were medically necessary.
Signature: _____
Date: 2024-06-17