



Aetna

HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☒ (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) W207070245									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Frost, Leo										3. PATIENT'S BIRTH DATE MM DD YY 04 03 1951 SEX ☐ M ☐ F									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Frost, Leo									
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE 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) ☐ 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										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 DATE										a. INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐ SEX									
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. OTHER CLAIM ID (Designated by NUCC)									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										c. INSURANCE PLAN NAME OR PROGRAM NAME Aetna Plan									
15. OTHER DATE QUAL MM DD YY										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.									
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) A. M25561 B. C. D. E. F. G. H. I. J. K. L. ICD Ind. 0									
22. RESUBMISSION CODE ORIGINAL REF. NO.										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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 07 22 26 07 22 26 11 99213 A 150.00 1 NPI 1083119925																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 X										26. PATIENT'S ACCOUNT NO. pat-gen-6									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO										28. TOTAL CHARGE \$ 150.00									
29. AMOUNT PAID \$ 9.90										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.) Signature on File										32. SERVICE FACILITY LOCATION INFORMATION Northstar Family Health - Main 1420 Birchwood Ave Portland, OR 97214									
33. BILLING PROVIDER INFO & PH # () Northstar Family Health																			
SIGNED DATE										a. 1982744321 b. a. 1982744321 b.									