



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) BCB251836718									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hayes, Mia										3. PATIENT'S BIRTH DATE MM DD YY 08 15 1987 SEX ☐ M ☐ F									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐									
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) ☐ YES ☒ NO b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) c. OTHER ACCIDENT? ☐ YES ☒ 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 DATE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield Plan d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 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									
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. M5450 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From 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 03 26 07 03 26 11 70551 A 2200.00 1 NPI 1740250123																			
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25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 X										26. PATIENT'S ACCOUNT NO. pat-gen-7									
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										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO									
32. SERVICE FACILITY LOCATION INFORMATION Northstar Family Health - Main 1420 Birchwood Ave Portland, OR 97214										28. TOTAL CHARGE \$ 2200.00 29. AMOUNT PAID \$ 0.00 30. Rsvd. for NUCC Use									
33. BILLING PROVIDER INFO & PH # () Northstar Family Health																			
SIGNED DATE										a. 1982744321 b. a. 1982744321 b.									