



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 ☒										1a. INSURED'S I.D. NUMBER (For Program in Item 1) OHP679524553									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Murphy, Aria										3. PATIENT'S BIRTH DATE MM DD YY 02 25 1951 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 ☐									
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										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) ☐ 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)									
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 Oregon Health Plan Plan									
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. SIGNED DATE									
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										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. J45909 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. #																			
1 08 12 26 08 12 26 11 80053 A 45.00 1 NPI 1932005518																			
2																			
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25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 X										26. PATIENT'S ACCOUNT NO. pat-gen-47									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO										28. TOTAL CHARGE \$ 45.00									
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.) 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.									