



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) BCB201716264	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lambert, Joseph		3. PATIENT'S BIRTH DATE MM DD YY 09 21 2001 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) Lambert, Joseph	
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		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)	
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		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX ☐ 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.	
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 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. R519 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. #			
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25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 X		26. PATIENT'S ACCOUNT NO. pat-gen-60 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	
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		28. TOTAL CHARGE \$ 4800.00 29. AMOUNT PAID \$ 316.80 30. Rsvd. for NUCC Use	
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. 1982744321	