



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) BCB207896991	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Greer, Jack		3. PATIENT'S BIRTH DATE ☐ MM ☐ DD ☐ YY ☐ SEX ☐ M ☐ F 02 03 1949 M	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Greer, Jack		5. PATIENT'S ADDRESS (No., Street) CITY STATE	
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) CITY STATE	
8. RESERVED FOR NUCC USE		9. 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)		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 ☐ MM ☐ DD ☐ YY QUAL	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION ☐ FROM ☐ MM ☐ DD ☐ YY ☐ TO ☐ MM ☐ DD ☐ YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES ☐ FROM ☐ MM ☐ DD ☐ YY ☐ TO ☐ MM ☐ DD ☐ YY	
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES		21. RESUBMISSION CODE ORIGINAL REF. NO.	
22. PRIOR AUTHORIZATION NUMBER		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From ☐ MM ☐ DD ☐ YY To ☐ MM ☐ DD ☐ YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 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 ☐ ☒ X		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	
28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 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 #			
SIGNED _____ DATE _____		a. b.	