



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) W331687381									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Holland, Abigail										3. PATIENT'S BIRTH DATE MM DD YY 03 13 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) Holland, Abigail									
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 SEX M ☐ F ☐									
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										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I10 B. C. D. E. F. G. H. I. J. K. L.										20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES									
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. #										22. RESUBMISSION CODE ORIGINAL REF. NO.									
25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 ☐ ☒ ☐										23. PRIOR AUTHORIZATION NUMBER									
26. PATIENT'S ACCOUNT NO. pat-gen-92										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									
a. 1982744321										b. 1982744321									