



Cigna

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) CIG675708837	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Murphy, Riley		3. PATIENT'S BIRTH DATE MM DD YY 05 18 1980 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) Murphy, Riley	
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 ☐ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Cigna 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 MM DD YY QUAL	
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) ICD Ind. 0		20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES	
A. K219 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER 84-2210094 SSN EIN ☒ X		26. PATIENT'S ACCOUNT NO. pat-gen-109 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 \$ 300.00 29. AMOUNT PAID \$ 19.80 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. a. 1982744321 b.	