



Cigna

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ ☐ PICA		PICA ☐ ☐	
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☒ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) CIG816226742	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Bishop, Grace		3. PATIENT'S BIRTH DATE MM DD YY 06 04 1962 SEX M ☐ F ☐	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Bishop, Grace		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT'S ADDRESS (No., Street)		7. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area 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		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 ☐	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐		b. OTHER CLAIM ID (Designated by NUCC)	
b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Cigna Plan	
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.	
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.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		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 _____ DATE _____		SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____		15. OTHER DATE QUAL _____ MM DD YY	
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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. _____		17b. NPI _____	
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. K219 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
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) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 08 15 26 08 15 26 11 99395 A 240.00 1 NPI 1083119925		2 3 4 5 6	
25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 ☐ ☒		26. PATIENT'S ACCOUNT NO. pat-gen-134	
27. ACCEPT ASSIGNMENT? (For govt claims, see back) ☐ YES ☐ NO		28. TOTAL CHARGE \$ 240.00 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.	
SIGNED _____ DATE _____		a. 1982744321 b.	