



Aetna

HEALTH INSURANCE CLAIM FORM

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

|                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                    |  |
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| <input type="checkbox"/> <input type="checkbox"/> PICA                                                                                                                                                                                                                      |  | <input type="checkbox"/> <input type="checkbox"/> PICA                                                                                                                                                                                                                                                                                                             |  |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)  |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)<br><b>W994682212</b>                                                                                                                                                                                                                                                                                             |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>Ramsey, Caleb</b>                                                                                                                                                                                           |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY <b>07 17 2006</b> SEX <input type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                    |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><br>CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )                                                                                                                                                                             |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>Ramsey, Caleb</b>                                                                                                                                                                                                                                                                                  |  |
| 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                           |  | 7. INSURED'S ADDRESS (No., Street)<br><br>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)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                        |  |
| b. RESERVED FOR NUCC USE                                                                                                                                                                                                                                                    |  | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)                                                                                                                                                                                                                                                                |  |
| c. RESERVED FOR NUCC USE                                                                                                                                                                                                                                                    |  | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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.<br><br>SIGNED DATE |  | a. INSURED'S DATE OF BIRTH<br>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX<br>b. OTHER CLAIM ID (Designated by NUCC)<br>c. INSURANCE PLAN NAME OR PROGRAM NAME<br><b>Aetna Plan</b><br>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d. |  |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)<br>MM DD YY QUAL                                                                                                                                                                                                    |  | 15. OTHER DATE<br>QUAL MM DD YY                                                                                                                                                                                                                                                                                                                                    |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE                                                                                                                                                                                                                              |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY                                                                                                                                                                                                                                                                                |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                                       |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY                                                                                                                                                                                                                                                                                 |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)<br>A. <b>J309</b> B. C. D. E. F. G. H. I. J. K. L.                                                                                                                                      |  | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> 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.<br>23. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                          |  |
| 1 06 30 26 06 30 26 11 99395 A 240.00 1 NPI 1740250123                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                    |  |
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| 6                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                    |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN<br><b>84-2210094</b> <input type="checkbox"/> <input checked="" type="checkbox"/>                                                                                                                                                       |  | 26. PATIENT'S ACCOUNT NO.<br><b>pat-gen-139</b>                                                                                                                                                                                                                                                                                                                    |  |
| 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.)<br><b>Signature on File</b>                                                                          |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                    |  |
| 32. SERVICE FACILITY LOCATION INFORMATION<br><b>Northstar Family Health - Main</b><br><b>1420 Birchwood Ave</b><br><b>Portland, OR 97214</b>                                                                                                                                |  | 28. TOTAL CHARGE \$ <b>240.00</b> 29. AMOUNT PAID \$ <b>0.00</b> 30. Rsvd. for NUCC Use                                                                                                                                                                                                                                                                            |  |
| SIGNED DATE                                                                                                                                                                                                                                                                 |  | 33. BILLING PROVIDER INFO & PH # ( )<br><b>Northstar Family Health</b><br>a. <b>1982744321</b> b.                                                                                                                                                                                                                                                                  |  |