



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) W694707936	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Brooks, Noah		3. PATIENT'S BIRTH DATE MM DD YY 07 11 1992 SEX ☐ M ☐ F	
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. 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		11. INSURED'S DATE OF BIRTH MM DD YY ☐ M ☐ F	
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. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.	
13. 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.	
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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
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. F411 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
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		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 ☐ ☒		26. PATIENT'S ACCOUNT NO. pat-gen-163	
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		34. BILLING PROVIDER INFO & PH # Northstar Family Health	
SIGNED DATE		a. 1982744321 b.	