



## 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>UHC841408548</b>                                                                                                                                                                                                                                                                                                                                               |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>Fleming, Amelia</b>                                                                                                                                                                                                 |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY <b>09 06 2007</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>Fleming, Amelia</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)<br>a. OTHER INSURED'S POLICY OR GROUP NUMBER<br>b. RESERVED FOR NUCC USE<br>c. RESERVED FOR NUCC USE<br>d. INSURANCE PLAN NAME OR PROGRAM NAME                                                                      |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>10d. CLAIM CODES (Designated by NUCC)                        |  |
| 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>SIGNED _____ DATE _____ |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>a. INSURED'S DATE OF BIRTH<br>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/><br>b. OTHER CLAIM ID (Designated by NUCC)<br>c. INSURANCE PLAN NAME OR PROGRAM NAME<br><b>UnitedHealthcare 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<br>17a. 17b. NPI                                                                                                                                                                                                                     |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY<br>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY                                                                                                                                                                                                                                              |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                                               |  | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES                                                                                                                                                                                                                                                                                                                                   |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)<br>A. <b>Z0000</b> B. C. D. E. F. G. H. I. J. K. L.                                                                                                                                             |  | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                                                                              |  |
| 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. #                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| 1 10 16 26 10 16 26 11 99205 A 400.00 1 NPI 1083119925                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
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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-165</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 <input type="checkbox"/> 29. AMOUNT PAID <input type="checkbox"/> 30. Rsvd. for NUCC Use<br><b>\$ 400.00 \$ 26.40</b>                                                                                                                                                                                                                                                                                 |  |
| SIGNED _____ DATE _____                                                                                                                                                                                                                                                             |  | 33. BILLING PROVIDER INFO & PH # ( )<br><b>Northstar Family Health</b><br>a. <b>1982744321</b> b.                                                                                                                                                                                                                                                                                                                      |  |