



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) UHC724969952	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mueller, Liam		3. PATIENT'S BIRTH DATE MM DD YY 07 01 1967 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 SEX ☐ 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. PATIENT'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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		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. J45909 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 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 06 29 26 06 29 26 11 99213 A 150.00 1 NPI 1932005518		2 _____ NPI _____	
3 _____ NPI _____		4 _____ NPI _____	
5 _____ NPI _____		6 _____ NPI _____	
25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 ☐ ☒		26. PATIENT'S ACCOUNT NO. pat-gen-164	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO		28. TOTAL CHARGE \$ 150.00 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. _____	