



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) BCB859155104	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hughes, Daniel		3. PATIENT'S BIRTH DATE ☐ MM ☐ DD ☐ YY ☐ SEX ☐ M ☐ F 02 16 1992 M	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Hughes, Daniel		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. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) c. OTHER ACCIDENT? ☐ YES ☒ NO 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 b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield Plan 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 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. SIGNED _____ DATE _____		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 _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) ☐ MM ☐ DD ☐ YY QUAL		15. OTHER DATE ☐ MM ☐ DD ☐ YY QUAL	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION ☐ FROM ☐ MM ☐ DD ☐ YY ☐ TO ☐ MM ☐ DD ☐ YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI	
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. N390 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) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
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25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☒ X		26. PATIENT'S ACCOUNT NO. pat-gen-171	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO		28. TOTAL CHARGE \$ 1800.00 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 #		a. 1982744321 b.	