



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) UHC817987481	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Barrett, Lily		3. PATIENT'S BIRTH DATE MM DD YY 04 17 1986 SEX ☐ M ☐ F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Barrett, Lily	
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) 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) ☐ 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		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. SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME UnitedHealthcare Plan d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.	
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		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. E785 B. C. D. E. F. G. H. I. J. K. L.		20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES 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. #			
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25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 ☐ ☒		26. PATIENT'S ACCOUNT NO. pat-gen-226	
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		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	
32. SERVICE FACILITY LOCATION INFORMATION Northstar Family Health - Main 1420 Birchwood Ave Portland, OR 97214		28. TOTAL CHARGE ☐ 29. AMOUNT PAID 30. Rsvd. for NUCC Use \$ 1400.00 \$ 0.00	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # () Northstar Family Health a. 1982744321 b.	