



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) UHC841202473	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Yates, Hazel		3. PATIENT'S BIRTH DATE MM DD YY 02 21 1965 SEX M ☐ F ☐	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Yates, Hazel		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT'S ADDRESS (No., Street)		7. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		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)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
c. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME UnitedHealthcare Plan	
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 _____		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	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. RESUBMISSION CODE ORIGINAL REF. NO.	
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. PRIOR AUTHORIZATION NUMBER	
23. 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. #	
1 04 03 26 04 03 26 11 99205 A 400.00 1 NPI 1083119925			
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25. FEDERAL TAX I.D. NUMBER 84-2210094		26. PATIENT'S ACCOUNT NO. pat-gen-219	
SSN EIN ☐ ☒		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	
28. TOTAL CHARGE \$ 400.00		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			
SIGNED _____ DATE _____		a. 1982744321 b. _____	