HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☑ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): RST123450988
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): aiden mooney	3. PATIENT'S BIRTH DATE MM DD YY: 06 07 41 SEX M ☐ F ☐
	4. INSURED'S NAME (Last Name, First Name, Middle Initial): MOONEY, AIDEN
5. PATIENT'S ADDRESS (No., Street):	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐
	7. INSURED'S ADDRESS (No., Street): 402 SOUTH CENTER
CITY:	STATE:
8. RESERVED FOR NUCC USE	CITY: ALBANY STATE: OR
ZIP CODE:	TELEPHONE (Include Area Code): ( )
	ZIP CODE: 97321 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:
	11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
	a. INSURED'S DATE OF BIRTH MM DD YY: 06 07 1941 SEX M ☑ F ☐
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):
	b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT? YES ☐ NO ☐
	c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC INSURANCE PLAN
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. CLAIM CODES (Designated by NUCC):
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☑ *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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: SOF DATE: 05/12/2016	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: SOF
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 12 16 QUAL.: 431	15. OTHER DATE QUAL.: MM DD YY
	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI 2313890
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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) ICD Ind. A. S91.311 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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. #
1 05 12 16 05 12 16	11		99202	1	F	$90 00	1	1	NPI	2313890
2 05 12 16 05 12 16	11		90715	1	F	30. 00	1		NPI	2313890
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 4217890908	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE: $ 100 00	29. AMOUNT PAID: -90 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.) SOF SIGNED DATE 05/14/16	32. SERVICE FACILITY LOCATION INFORMATION: ACUMEN MEDICAL PRACTICE 791 NORTH LANE SOMEWHERE, OREGON 12345 a. X100X1000 b.		33. BILLING PROVIDER INFO & PH # ( ): ACUMEN MEDICAL PRACTICE 791 NORTH LANE SOMEWHERE,OREGON 12345 a. X100X1000 b.		