



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>												PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) R94353887											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BUTLER, DANIELLE						3. PATIENT'S BIRTH DATE MM DD YY 04 29 1989 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F						4. INSURED'S NAME (Last Name, First Name, Middle Initial) DAVIS, TRAVIS											
5. PATIENT'S ADDRESS (No., Street) 989 NE OAK CIRCLE						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 989 NE OAK CIRCLE											
CITY CANBY				STATE OR				CITY CANBY				STATE OR											
ZIP CODE 97013				TELEPHONE (Include Area Code) (503)-313-2389				ZIP CODE 97013				TELEPHONE (Include Area Code) (503)-313-2389											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER 10017475											
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY 01 04 1989 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F						b. OTHER CLAIM ID (Designated by NUCC)											
b. RESERVED FOR NUCC USE						c. INSURANCE PLAN NAME OR PROGRAM NAME						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
c. RESERVED FOR NUCC USE						d. INSURANCE PLAN NAME OR PROGRAM NAME						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 SIGNATURE ON FILE DATE 04 28 2022											
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 SIGNATURE ON FILE DATE 04 28 2022												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 SIGNATURE ON FILE											
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. F411 B. F422 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____											
23. PRIOR AUTHORIZATION NUMBER C00462012												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. #											
11 28 22 11 28 22 10				90837				AB				14000 1				811329904 1033221296							
2				3				4				5				6							
25. FEDERAL TAX I.D. NUMBER 811329904 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. 00385						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
28. TOTAL CHARGE \$ 14000						29. AMOUNT PAID \$ 000						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 SIGNED 12212022												32. SERVICE FACILITY LOCATION INFORMATION LYNNE COON COUNSELING, LLC 1340 SW BERTHA BLVD, SUITE PORTLAND, OR 97219-2096 a. 1033221296 b. 811329904											
33. BILLING PROVIDER INFO & PH # (503)-243-2283 LYNNE COON COUNSELING, LLC 1340 SW BERTHA BLVD, SUITE 202 PORTLAND, OR 97219-2096 a. 1033221296 b. _____																							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION