



HEALTH INSURANCE CLAIM FORM

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

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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) 89167595
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HEWS, ELLIS	3. PATIENT'S BIRTH DATE MM DD YY 02 06 1994 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F
5. PATIENT'S ADDRESS (No., Street) 6236 NE 18TH AVE	6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY PORTLAND STATE OR	7. INSURED'S ADDRESS (No., Street) 6236 NE 18TH AVE
ZIP CODE 97211 TELEPHONE (Include Area Code) (714)-331-1063	CITY PORTLAND STATE OR
ZIP CODE 97211 TELEPHONE (Include Area Code) (714)-331-1063	CITY PORTLAND STATE OR
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER	11. INSURED'S DATE OF BIRTH MM DD YY 02 06 1994 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F
a. INSURED'S DATE OF BIRTH MM DD YY 02 06 1994 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	b. OTHER CLAIM ID (Designated by NUCC)
b. RESERVED FOR NUCC USE	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	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>
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.
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 05 03 2022	SIGNED SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	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	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. F411 B. _____ C. _____ D. _____	23. PRIOR AUTHORIZATION NUMBER C00463003
E. _____ F. _____ G. _____ H. _____	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. #
I. _____ J. _____ K. _____ L. _____	1 12 01 22 12 01 22 10 90837 A 14000 1 NPI 811329904 1033221296
25. FEDERAL TAX I.D. NUMBER 811329904 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 00386
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
33. BILLING PROVIDER INFO & PH # (503)-243-2283	a. 1033221296 b. 811329904
a. 1033221296 b. 811329904	a. 1033221296 b. 811329904

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION