Create Date:

Sender's EDI No:

MODA HEALTH PLANS
PO BOX 40384
PORTLAND, OR 97240

# HEALTH INSURANCE CLAIM FORM

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

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| 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) |
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| 2. PATIENT'S NAME (Last Name,First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE SEX M F | 4. INSURED'S NAME(Last Name,First Name ,Middle Initial) |
|---|---|---|
| 5. PATIENT'S ADDRESS (No.,Street) | 6. PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No.,Street) |
| CITY / STATE | 8. RESERVED FOR NUCC USE | CITY / STATE |
| ZIP CODE / TELEPHONE (Include Area Code) | | ZIP CODE / TELEPHONE (Include Area Code) |
| 9. OTHER INSURED'S NAME (Last,First, 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 SEX M F |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) YES NO | b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| 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. |

| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other info 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 | 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 |
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| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL | 15. OTHER DATE QUAL | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO |
|---|---|---|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. / 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? $ CHARGES YES NO |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L. | | 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) CPT/HCPCS | MODIFIER | 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 | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? YES NO | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. Rsvd for NUCC Use |
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| 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.) SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION a. b. | 33. BILLING PROVIDER'S INFO & PH # a. b. |
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NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING