# 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): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cynthia Rodriguez

3. PATIENT'S BIRTH DATE MM DD YY: 10 20 1960 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Cynthia Rodriguez

5. PATIENT'S ADDRESS (No., Street): 105 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 105 Main Street

CITY: Portland STATE: OR

8. RESERVED FOR NUCC USE

CITY: Portland STATE: OR

ZIP CODE: 97202 TELEPHONE (Include Area Code): (800) 555-2000

ZIP CODE: 97202 TELEPHONE (Include Area Code): (800) 555-2000

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: 12345

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY: 10 20 1960 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: Employer Plan ABC

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: Signature on file DATE: 05-12-2025

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 QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY 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. Z00.01 B. R73.03 C. Z13.1 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 | 25 | | | 10 | | 99385 | 95 | C | 150 00 | 1 | | NPI | 1013990555 |
| 2 | 05 | 12 | 25 | | | 10 | | 99422 | 95 | | 0 00 | 0 | | NPI | 1013990555 |
| 3 | 05 | 12 | 25 | | | 10 | | 99401 | 95 | A | 50 00 | 1 | | NPI | 1013990555 |
| 4 | 05 | 12 | 25 | | | 10 | | 80061 | | B | 50 00 | 1 | | NPI | 1013990555 |
| 5 | 05 | 12 | 25 | | | 10 | | 82947 | | C | 75 00 | 1 | | NPI | 1013990555 |
| 6 | 05 | 12 | 25 | | | 10 | | G0444 | 95 | | 0 00 | 0 | | NPI | 1013990555 |

25. FEDERAL TAX I.D. NUMBER: 99-4567305 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ 325 00

29. AMOUNT PAID: $

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 6/4/25

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Reperio Health Medical Group, PLLC
4784 SE 17th Avenue
Portland, OR 97202

a. 1982438362 b.

33. BILLING PROVIDER INFO & PH # (844) 504-0402

Alex Marsh, MD
Reperio Health Medical Group, PLLC
4784 SE 17th Avenue
Portland, OR 97202

a. 1013990555 b.