



HEALTH INSURANCE

APPROVED BY NATIONAL UNIFORM CLAIMS

FORM

NUCC (NUCC) 02-12

LIBERTY MUTUAL WC
PO BOX 7204

London, KY 40742

CARRIER

1. MEDICARE MEDICAID <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ANGUIANO ROSALES FRANCISCO J		3. PATIENT'S BIRTH DATE 09/09/1987 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) ANGUIANO ROSALES FRANCISCO J		5. INSURED'S ADDRESS (No., Street) 11440 SW ESAZL PL	
6. PATIENT'S ADDRESS (No., Street) 18633 SW BLANTON		7. INSURED'S ADDRESS (No., Street) 11440 SW ESAZL PL		8. INSURED'S CITY PORTLAND		9. INSURED'S STATE OR		10. INSURED'S ZIP CODE 97223	
11. INSURED'S POLICY GROUP OR FECA NUMBER DOI1292024		12. INSURED'S DATE OF BIRTH 10/01/67 M <input type="checkbox"/> F <input type="checkbox"/>		13. INSURED'S OTHER CLAIM ID (Designated by NUCC)		14. INSURED'S INSURANCE PLAN NAME OR PROGRAM NAME		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
16. 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 10/25/24		17. 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 10/25/24		18. DATE OF CURRENT ILLNESS MM DD YY 01/29/2024		19. NAME OF REFERRING PHYSICIAN DR. Mckeown James		20. ADDITIONAL CLAIM INFORMATION	
21. DIAGNOSIS OR NATURE OF ILLNESS A. M25531 B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VV. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.		22. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		23. TOTAL CHARGE \$ 148.00		24. AMOUNT PAID \$ 0.00		25. Revd for NUCC Use	
26. SIGNATURE OF PHYSICIAN 1500 Be		27. SIGNATURE OF SUPPLIER 1700		28. SIGNATURE OF PATIENT 1700		29. SIGNATURE OF INSURED 1700		30. SIGNATURE OF AUTHORIZED PERSON 1700	
31. SIGNATURE OF PHYSICIAN 1500 Be		32. SIGNATURE OF SUPPLIER 1700		33. SIGNATURE OF PATIENT 1700		34. SIGNATURE OF INSURED 1700		35. SIGNATURE OF AUTHORIZED PERSON 1700	
36. SIGNATURE OF PHYSICIAN 1500 Be		37. SIGNATURE OF SUPPLIER 1700		38. SIGNATURE OF PATIENT 1700		39. SIGNATURE OF INSURED 1700		40. SIGNATURE OF AUTHORIZED PERSON 1700	
39. SIGNATURE OF PHYSICIAN 1500 Be		40. SIGNATURE OF SUPPLIER 1700		41. SIGNATURE OF PATIENT 1700		42. SIGNATURE OF INSURED 1700		43. SIGNATURE OF AUTHORIZED PERSON 1700	
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49. SIGNATURE OF PHYSICIAN 1500 Be		50. SIGNATURE OF SUPPLIER 1700		51. SIGNATURE OF PATIENT 1700		52. SIGNATURE OF INSURED 1700		53. SIGNATURE OF AUTHORIZED PERSON 1700	
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79. SIGNATURE OF PHYSICIAN 1500 Be		80. SIGNATURE OF SUPPLIER 1700		81. SIGNATURE OF PATIENT 1700		82. SIGNATURE OF INSURED 1700		83. SIGNATURE OF AUTHORIZED PERSON 1700	
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89. SIGNATURE OF PHYSICIAN 1500 Be		90. SIGNATURE OF SUPPLIER 1700		91. SIGNATURE OF PATIENT 1700		92. SIGNATURE OF INSURED 1700		93. SIGNATURE OF AUTHORIZED PERSON 1700	
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99. SIGNATURE OF PHYSICIAN 1500 Be		100. SIGNATURE OF SUPPLIER 1700		101. SIGNATURE OF PATIENT 1700		102. SIGNATURE OF INSURED 1700		103. SIGNATURE OF AUTHORIZED PERSON 1700	
104. SIGNATURE OF PHYSICIAN 1500 Be		105. SIGNATURE OF SUPPLIER 1700		106. SIGNATURE OF PATIENT 1700		107. SIGNATURE OF INSURED 1700		108. SIGNATURE OF AUTHORIZED PERSON 1700	
109. SIGNATURE OF PHYSICIAN 1500 Be		110. SIGNATURE OF SUPPLIER 1700		111. SIGNATURE OF PATIENT 1700		112. SIGNATURE OF INSURED 1700		113. SIGNATURE OF AUTHORIZED PERSON 1700	
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