



Create Date:

Sender's EDI No:

SUMMIT HEALTH PLANS
PO BOX 820070
PORTLAND, OR 97282
FAX: (855) 522-9810

HEALTH INSURANCE CLAIM FORM

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

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/GROUP HEALTH PLAN/FECA BLK LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT'S RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. RESERVED FOR NUCC USE; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP); 15. OTHER DATE; 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION; 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE; 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES; 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC); 20. OUTSIDE LAB? \$ CHARGES; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSTD Family Plan; I. ID QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. Rsvd for NUCC Use; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER'S INFO & PH #.