Create Date:

Sender's EDI No:

HEALTH INSURANCE CLAIM FORM

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

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

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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)
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
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? YES ☐ NO ☐ $ CHARGES	
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. #
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

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

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.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-1197
FORM 1500 (02-12)

1257 (02/21)