HEALTH INSURANCE CLAIM FORM

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

PICA

BLUE SKY HEALTH INSURANCE
P.O. BOX 84120
PORTLAND, OR 97208-4120

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
				X		

1a. INSURED'S I.D. NUMBER (For Program in Item 1): BSH 4827193 02

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CHEN. MARGARET L	06 14 78	M F X	CHEN. MARGARET L

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
4827 MAPLE RIDGE DR	Self X Spouse Child Other	4827 MAPLE RIDGE DR

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
BEAVERTON	OR		BEAVERTON	OR

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
97005	(50) 555-0142	97005	(50) 555-0142

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
CHEN. DAVID R		GRP-558220-A
a. OTHER INSURED'S POLICY OR GROUP NUMBER: AET-W3387204-01	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY: 06 14 78 SEX M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE SKY HEALTH PPO 4000
d. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA OPEN ACCESS PPO	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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: 03/12/2026

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) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
03 12 26 QUAL. 431	QUAL.	FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
	71b. NPI	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.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. I10 B. E78.5 C. Z00.00 D.	0		
E. F. G. H.		23. PRIOR AUTHORIZATION NUMBER	
I. J. K. L.			

	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	03 12 26	03 12 26	1	1	99214		ABC	185 00	1		NPI	1234567890
2	03 12 26	03 12 26	1	1	93000		A	45 00	1		NPI	1234567890
3	03 12 26	03 12 26	1	1	36415		A	18 00	1		NPI	1234567890
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
93-1847562 X	CHN-202603-11	X YES NO	$ 248 00	$ 25 00	$ 223 00

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (50) 555-0298
SIGNED 03/12/2026 DATE SOF	WESTSIDE FAMILY MED 9275	WESTSIDE FAMILY MED 9275 HA
	a. 170020394 b. G2-WFM-OR-28	a. 170020394 b. G2-OR-PROV-8

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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