



HNS/ABSOLUTE TOTAL CARE
 PO BOX 2368
 CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

CARRIER

<input type="checkbox"/> <input type="checkbox"/> PICA PICA <input type="checkbox"/>																					
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0000001																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN A					3. PATIENT'S BIRTH DATE SEX 01 01 1980 M <input checked="" type="checkbox"/> <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JOHN A											
5. PATIENT'S ADDRESS (No., Street) 123 ABC STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 ABC STREET											
CITY ANYTOWN			STATE US		8. RESERVED FOR NUCC USE					CITY ANYTOWN			STATE US								
ZIP CODE 00001		TELEPHONE (Include Area Code) ()			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					ZIP CODE 00001		TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER ATC											
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>											
b. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME ATC											
d. INSURANCE PLAN NAME OR PROGRAM NAME					11. INSURED'S POLICY GROUP OR FECA NUMBER					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
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.					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 _____ DATE _____										SIGNED _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 03 01 21 QUAL.					15. OTHER DATE QUAL. MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
17b. NPI _____					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE 7 ORIGINAL REF. NO. CORRECTED					23. PRIOR AUTHORIZATION NUMBER						
A. M99.03		B. M99.02		C. M99.01		D. _____		E. _____		F. _____		G. _____		H. _____		I. _____		J. _____			
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/HCP/CS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSCOT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
03 02 21 03 02 21		11		98941				ABC		40 00		1		NPI		0000000001					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER SSN EIN 01-0000001 <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 00001					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 40 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.) JOHN Q CHIROPRACTOR DC SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION CHIROPRACTOR'S OFFICE 123 ANY STREET ANYTOWN US 00001					33. BILLING PROVIDER INFO & PH # (001) 001-0001 JOHN Q CHIROPRACTOR DC PO BOX 000 ANYTOWN US 00001											
a. 0000000002					b. _____					a. 0000000002		b. _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION