



HNS/ABSOLUTE TOTAL CARE
 PO BOX 2368
 CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

SECONDARY CLAIM

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>										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 MM DD YY SEX 01 01 1980 M <input checked="" type="checkbox"/> F <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) ()			ZIP CODE 00001		TELEPHONE (Include Area Code) ()												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JOHN A					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER ATC a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME ATC d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>									
a. OTHER INSURED'S POLICY OR GROUP NUMBER PRIMARY INSURANCE ID #					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 _____ 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 _____ DATE _____									
b. RESERVED FOR NUCC USE					14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 03 01 22					15. OTHER DATE MM DD YY QUAL.									
c. RESERVED FOR NUCC USE					17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
d. INSURANCE PLAN NAME OR PROGRAM NAME PRIMARY INSURANCE NAME					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M99.03 B. M99.02 C. M99.01 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 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. EPSCOT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
1 03 02 22 03 02 22		11		98941 AT			ABC	40 00		1		NPI 0000000001							
2												NPI							
3												NPI							
4												NPI							
5												NPI							
6												NPI							
25. FEDERAL TAX I.D. NUMBER 01-0000001 SSN EIN <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 a. 0000000002 b.					33. BILLING PROVIDER INFO & PH # (001) 001-0001 JOHN Q CHIROPRACTOR DC PO BOX 000 ANYTOWN US 00001 a. 0000000002 b.				

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION