HNS/BCBS
PO BOX 2368
CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): YPPW0000000002

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE JANE A

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1990 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE JOHN Q

5. PATIENT'S ADDRESS (No., Street): 123 ABC STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 ABC STREET

CITY: ANYTOWN STATE: US

8. RESERVED FOR NUCC USE

CITY: ANYTOWN STATE: US

ZIP CODE: 00000 TELEPHONE (Include Area Code): ( )

ZIP CODE: 00000 TELEPHONE (Include Area Code): ( )

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: 00001

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 02 01 1989 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State): NC

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBS

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] 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 ______ 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 ______

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 01 2015 QUAL.

15. OTHER DATE QUAL. 439 MM DD YY: 04 01 2015

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. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

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. 9

A. 847.1 B. 739.1 C. 739.3 D. 724.1
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	02	15	04	02	15	11		99203	25	ABCD	75	00	1		NPI	0000000001
2	04	02	15	04	02	15	11		72100		ABCD	75	00	1		NPI	0000000001
3	04	02	15	04	02	15	11		98941		ABCD	50	00	1		NPI	0000000001
4	04	02	15	04	02	15	11		97140	59	ABCD	40	00	1		NPI	0000000001
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER: 00-0000000 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 00001

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 240 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 OFFICE
345 ANY STREET
ANYTOWN US 00000
a. 0000000002 b.

33. BILLING PROVIDER INFO & PH # ( )
JOHN Q CHIROPRACTOR
PO BOX 123
ANYTOWN US 00000
a. 0000000002 b.