



HNS/BCBS  
 PO BOX 2368  
 CORNELIUS NC  
 28031

**HEALTH INSURANCE CLAIM FORM**

**CORRECTED**

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

CARRIER

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 checked="" 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) <b>YPPW000000001</b>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JANE A</b>					3. PATIENT'S BIRTH DATE MM DD YY SEX <b>01 01 1990 M <input type="checkbox"/> F <input checked="" type="checkbox"/></b>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE JANE A</b>																			
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC STREET</b>					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) <b>123 ABC STREET</b>																			
CITY <b>ANYTOWN</b>			STATE <b>US</b>		8. RESERVED FOR NUCC USE					CITY <b>ANYTOWN</b>			STATE <b>US</b>																
ZIP CODE <b>00000</b>		TELEPHONE (Include Area Code) <b>( )</b>								ZIP CODE <b>00000</b>		TELEPHONE (Include Area Code) <b>( )</b>																	
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 <b>00001</b>																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F																			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>BCBS</b>																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					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>																			
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 _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. <b>04 01 21</b>					15. OTHER DATE MM DD YY QUAL.					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 _____										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b>																			
A. <b>M99.03</b>		B. <b>M99.02</b>		C. <b>M99.01</b>		D. _____		E. _____		F. _____		G. _____		H. _____		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/HCP/CS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSCOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										22. RESUBMISSION CODE <b>7</b> ORIGINAL REF. NO. <b>BCBS Claim Ref #</b>																			
23. PRIOR AUTHORIZATION NUMBER										25. FEDERAL TAX I.D. NUMBER <b>01-0000001</b> SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>																			
25. FEDERAL TAX I.D. NUMBER <b>01-0000001</b>					26. PATIENT'S ACCOUNT NO. <b>00001</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>90 00</b>					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.) <b>JOHN Q CHIROPRACTOR DC</b> SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION <b>CHIROPRACTOR'S OFFICE</b> <b>123 ANY STREET</b> <b>ANYTOWN US 00001</b> a. <b>0000000002</b> b. _____										33. BILLING PROVIDER INFO & PH # <b>(001)001-0001</b> <b>JOHN Q CHIROPRACTOR DC</b> <b>PO BOX 000</b> <b>ANYTOWN US 00001</b> a. <b>0000000002</b> b. _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION