HEALTH INSURANCE CLAIM FORM

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

PICA

HNS/BCBS
PO BOX 2368
CORNELIUS NC
28031

CORRECTED

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
1. [ ] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [X] (ID#) [ ] (ID#) [ ] (ID#)	YPPW0000000001
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 JANE A	
5. PATIENT'S ADDRESS (No., Street) 123 ABC STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] 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 [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]	
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 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 01 2015 QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. 739.3 B. 739.2 C. 739.1 D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: BCBS Claim Ref # 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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04 01 15	04 01 15	11		98941		ABC	55 00	1		NPI	0000000001
2	04 01 15	04 01 15	11		97012		ABC	35 00	1		NPI	0000000001
3											NPI	
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. Rsvd for NUCC Use
00-0000000	[ ]	[X]	00001	[X] YES [ ] NO	$ 90 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 # ( )
JOHN Q CHIROPRACTOR DC	CHIROPRACTOR OFFICE 123 ANY STREET ANYTOWN US 00000	JOHN Q CHIROPRACTOR PO BOX 123 ANYTOWN US 00000
SIGNED DATE	a. 0000000002 b.	a. 0000000002 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION