HEALTH INSURANCE CLAIM FORM

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

PICA

HNS/HEALTHSPRING
PO BOX 2368
CORNELIUS NC 28031

CARRIER

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ( ) (Medicare#) MEDICAID ( ) (Medicaid#) TRICARE ( ) (ID#/DoD#) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (ID#) FECA BLK LUNG ( ) (ID#) OTHER ( ) (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 00000001
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE JANE S	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1950 SEX M ( ) F (X)		4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE JANE S
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: H00000001
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ( ) NO (X)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ( ) NO (X)		c. INSURANCE PLAN NAME OR PROGRAM NAME: HEALTHSPRING
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) 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 21 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. 0 A. M99.03 B. M99.01 C. 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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04 01 21	04 01 21	11		98940	AT	AB	50 00	1		NPI	0000000001
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 01-0000001 ( ) (X)	26. PATIENT'S ACCOUNT NO.: 00001	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES ( ) NO	28. TOTAL CHARGE: $ 50 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) 001-00001 JOHN Q CHIROPRACTOR DC PO BOX 000 ANYTOWN US 00001 a. 0000000002 b.	