



HEALTH INSURANCE CLAIM FORM

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

HNS/HEALTHSPRING
PO BOX 2368
CORNELIUS NC 28031

CORRECTED

CARRIER

Form with 33 numbered sections containing patient information, insurance details, and provider information. Includes fields for name, address, birth date, policy number, and signature.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION