

HEALTH INSURANCE CLAIM FORM

HNS/ HTA
PO BOX 2368
CORNELIUS NO

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 CORNELIUS NC 28031

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1. MEDICARE MEDICAID	TRICARE	CHAMPV	A GROUP HEALTH PL	FECA AN BLK LUNG	OTHER	1a. INSURED'S I.D. NU	JMBER		(For Program in Ite	em 1)
(Medicare#) (Medicaid#,	O#) (ID#)	-AN (ID#)	XXXXXXXX							
2. PATIENT'S NAME (Last Name, I	First Name, Middle Initia	11)	3. PATIENT'S BIRT	TH DATE	SEX	4. INSURED'S NAME (L	ast Name, Fi	rst Name, M	iddle Initial)	
DOE JOHN A	01 01	1950 [™] X	DOE JOHN A							
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)				
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ANYTOWN US			8. RESERVED FOR NUCC USE			CITY STATE				TE
111(110)(11)						ANYTOWN US				US
ZIP CODE TELEPHONE (Include Area Code)						ZIP CODE TELEPHONE (Include Area Code)				
00000	10. IS PATIENT'S CONDITION RELATED TO:			00000						
9. OTHER INSURED'S NAME (La	10. IS PATIENT'S C	CONDITION RELAT	11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a EMPLOYMENT2	(Current or Provious	HTA					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH MM DD YY				
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?			b. OTHER CLAIM ID (Designated by NUCC)						
				'ES X NO	LACE (State)	b. OTHER CLAIM ID (I	Jesignated by	y NUCC)		
c. RESERVED FOR NUCC USE	C. OTHER ACCIDE	_	ANYTOWN ZIP CODE 00000 11. INSURED'S POLICY GROUP OR FECA NUMBER HTA a. INSURED'S DATE OF BIRTH MM DD YY D. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME HEALTH TEAM ADVANTAGE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?							
The state of the s	YES X NO			TIP AT THE AND						
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CODE		UCC)	HEALTH TEAM ADVANTAGE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
S. HOOF WITCH I EAR HANGE ON	Tod, CLAIN CODE	C (Designated by N	YES NO If yes, complete items 9, 9a, and 9d.							
READ	& SIGNING THIS FORM.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize						
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 services described below.								ned physician or sup	plier for	
below.	deat payment or govern	ment benefits ettrer	to mysell of to the par	nty who accepts assi	griment	services described	below.			
SIGNED DATE						SIGNED				
14. DATE OF CURRENT ILLNES:	OTHER DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
01 01 20 QU	AL.	MM DD	YY	FROM DL	, , , ,	то	MM DD	YY		
17. NAME OF REFERRING PRO	-			18. HOSPITALIZATION	DATES RELA	TED TO CU	RRENT SERVICES	YY		
	. NPI			FROM		то				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB?		\$ CI	HARGES	
							NO			
21. DIAGNOSIS OR NATURE OF I	LLNESS OR INJURY F	Relate A-L to service	line below (24E)	ICD Ind. 0		22. RESUBMISSION CODE	, 0	RIGINAL RI	EF. NO.	
A. LM99.03_	D									
E	н. 📖			23. PRIOR AUTHORIZATION NUMBER						
I	J. L	K. L		L	1 -					
24. A. DATE(S) OF SERVICE	E B. FO PLACE OF		DURES, SERVICES, in Unusual Circumsta		E. DIAGNOSIS	F.	G. I DAYS EP OR Fa UNITS P	H. I. SDT ID. Imily ID.	J. RENDERI	NG ID. #
MM DD YY MM D	D YY SERVICE	EMG CPT/HCP	CS M	ODIFIER	POINTER	\$ CHARGES	UNITS P	lan QUAL.	PROVIDER	ID. #
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AG			(For govt, claims, see back)			28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use				
01- 0000001		DOE12				\$ 50 00 \$				
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C	CILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # (001) 001-0001						
(I certify that the statements or	RACTOR'S OF	FFICE	JOHN Q CHIROPRACTOR DC							
apply to this bill and are made	STREET		PO BOX 000							
JOHN Q CHIROPRA	VN, US 00001			ANYTOWN US 00001						
SIGNED	002 b.		a. 0000000002 b.							