



HEALTH INSURANCE CLAIM FORM

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

HNS/ HTA
PO BOX 2368
CORNELIUS NC 28031

CARRIER

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/... 2. PATIENT'S NAME: DOE JOHN A 3. PATIENT'S BIRTH DATE: 01/01/1950 4. INSURED'S NAME: DOE JOHN A 5. PATIENT'S ADDRESS: 123 ANY STREET 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [] Child [] Other [] 7. INSURED'S ADDRESS: 123 ANY STREET 8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER: HTA 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 01/01/2015 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. ADDITIONAL CLAIM INFORMATION 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: M99.03, M99.02 22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER 24. A. DATE(S) OF SERVICE 25. FEDERAL TAX I.D. NUMBER: XX-XXXXXXX 26. PATIENT'S ACCOUNT NO.: DOE1234 27. ACCEPT ASSIGNMENT? [X] YES [] NO 28. TOTAL CHARGE: \$ 50.00 29. AMOUNT PAID 30. Rsvd for NUCC Use 31. SIGNATURE OF PHYSICIAN OR SUPPLIER: CHIROPRACTOR, JOHN Q DC 32. SERVICE FACILITY LOCATION INFORMATION: CHIROPRACTOR'S OFFICE 123 ABC STREET ANYTOWN, US 00001 33. BILLING PROVIDER INFO & PH #: CHIROPRACTOR'S OFFICE 123 ABC STREET ANYTOWN, US 00001

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION