



HNS/PRUITTHEALTH
 PO BOX 2368
 CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

CARRIER

<input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> PICA																																																																																									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 00000001					2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN A					3. PATIENT'S BIRTH DATE MM DD YY SEX 01 01 2000 M <input checked="" type="checkbox"/> <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JOHN A																																																																															
5. PATIENT'S ADDRESS (No., Street) 123 ABC STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 ABC STREET					8. RESERVED FOR NUCC USE																																																																																				
CITY ANYTOWN STATE US					CITY ANYTOWN STATE US					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 PRUITT																																																																															
ZIP CODE 00001 TELEPHONE (Include Area Code) ()					ZIP CODE 00001 TELEPHONE (Include Area Code) ()					a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)					b. OTHER CLAIM ID (Designated by NUCC)																																																																																				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME PRUITTHEALTH					c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																																																																																				
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.					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 _____										DATE _____										SIGNED _____																																																																															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 04 01 2015 QUAL.										15. OTHER DATE MM DD YY QUAL.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																															
17b. NPI _____										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) M99.03 ICD Ind. 10										A. _____ B. _____ C. _____ D. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																															
E. _____ F. _____ G. _____ H. _____										I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER 000001																																																																															
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/HCP/CS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSCOT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1 09 13 18 09 13 18 11 98941 A 50 00 1 NPI 0000000001										2 09 13 18 09 13 18 11 97012 A 40 00 1 NPI 0000000001										3 NPI										4 NPI										5 NPI										6 NPI																																																	
25. FEDERAL TAX I.D. NUMBER 01-0000001 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 0001										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 90 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										32. SERVICE FACILITY LOCATION INFORMATION CHIROPRACTOR OFFICE 123ANY STREET ANYTOWN US 00001										33. BILLING PROVIDER INFO & PH # (001) 001-0001 JOHN Q CHIROPRACTOR PO BOX 000 ANYTOWN US 00001																																																																															
SIGNED _____										DATE _____										a. 0000000002										b. _____										a. 0000000002										b. _____																																																	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION