



HNS/SELECT HEALTH
 PO BOX 2368
 CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

CORRECTED CLAIM

CARRIER

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA							
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>				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					
CITY ANYTOWN		STATE US		CITY ANYTOWN		STATE US			
ZIP CODE 00001		TELEPHONE (Include Area Code) ()		ZIP CODE 00001		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)					
11. INSURED'S POLICY GROUP OR FECA NUMBER FIRST CHOICE VIP CARE PLUS				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER CLAIM ID (Designated by NUCC)				c. INSURANCE PLAN NAME OR PROGRAM NAME FIRST CHOICE VIP CARE PLUS					
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
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 _____					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 04 01 21 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. _____ 17b. NPI _____					
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				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) ICD Ind. 0					
A. M99.01 B. M99.02 C. M99.03 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				22. RESUBMISSION CODE 7 ORIGINAL REF. NO. Ref # most recently processed claim					
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/HCP/CS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					
1 04 05 21 04 05 21 11 98941 ABC 50 00 1 NPI 000000001				2					
3				4					
5				6					
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 \$ 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				32. SERVICE FACILITY LOCATION INFORMATION CHIROPRACTOR'S OFFICE 123 ANY STREET ANYTOWN US 00001					
SIGNED _____ DATE _____				33. BILLING PROVIDER INFO & PH # (001) 001-0001 JOHN Q CHIROPRACTOR DC PO BOX 000 ANYTOWN US 00001					
a. 000000002				b.		a. 000000002		b.	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION