



HNS/SELECT HEALTH  
PO BOX 2368  
CORNELIUS NC 28031

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
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) <b>00000001</b>																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN A</b>										3. PATIENT'S BIRTH DATE MM DD YY SEX <b>01 01 2000 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN A</b>																																							
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC STREET</b>										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) <b>123 ABC STREET</b>																																							
CITY <b>ANYTOWN</b> STATE <b>US</b>										8. RESERVED FOR NUCC USE										CITY <b>ANYTOWN</b> STATE <b>US</b>																																							
ZIP CODE <b>00001</b> TELEPHONE (Include Area Code) ( )										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 <b>FIRST CHOICE</b>																													
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)																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME <b>FIRST CHOICE</b>																																							
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 <i>If yes, complete items 9, 9a, and 9d.</i>																																							
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.  SIGNED _____ DATE _____															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 _____																																												
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) <b>04 01 21</b> 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) ICD Ind. <b>0</b> A. <b>M99.01</b> B. <b>M99.02</b> C. <b>M99.03</b> D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____															22. RESUBMISSION CODE ORIGINAL REF. NO.															23. PRIOR AUTHORIZATION NUMBER <b>00001 (req if under 18 yrs. old)</b>																													
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. #																																																	
<b>1</b> 04 05 21 04 05 21 11 98941 ABC 50 00 1 NPI 0000000001										<b>2</b> 04 05 21 04 05 21 11 72040 ABC 40 00 1 NPI 0000000001										<b>3</b> NPI																																							
<b>4</b> NPI										<b>5</b> NPI										<b>6</b> NPI																																							
25. FEDERAL TAX I.D. NUMBER <b>01-0000001</b> SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. <b>0001</b>										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>90 00</b>										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.) <b>JOHN Q CHIROPRACTOR DC</b> SIGNED _____ DATE _____															32. SERVICE FACILITY LOCATION INFORMATION <b>CHIROPRACTOR'S OFFICE</b> <b>123 ANY STREET</b> <b>ANYTOWN US 00001</b> a. <b>0000000002</b> b.															33. BILLING PROVIDER INFO & PH # ( 001 ) <b>001-0001</b> <b>JOHN Q CHIROPRACTOR DC</b> <b>PO BOX 000</b> <b>ANYTOWN US 00001</b> a. <b>0000000002</b> b.																													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION