



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) 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"/>		
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"/>		
CITY ANYTOWN STATE US			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)		
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.			11. INSURED'S POLICY GROUP OR FECA NUMBER FIRST CHOICE		
SIGNED _____ DATE _____			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 SELECT HEALTH		
			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.		
SIGNED _____ DATE _____			SIGNED _____		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 04 01 2015			15. OTHER DATE MM DD YY QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
17a. _____ 17b. NPI _____			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. 9			22. RESUBMISSION CODE ORIGINAL REF. NO.		
A. 739.1 B. 739.2 C. 739.3 D. _____ 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. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		
1 04 05 15 04 05 15 11 98941 ABC 50 00 1 NPI 0000000001					
2 04 05 15 04 05 15 11 72040 ABC 40 00 1 NPI 0000000001					
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 \$ 90 00 29. AMOUNT PAID \$		
30. Rsvd for NUCC Use			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. _____		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION