



HNS/CIGNA  
 PO BOX 2368  
 CORNELIUS NC 28031

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA <input type="checkbox"/></span>												
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 checked="" 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) <b>U000000001</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JANE S</b>					3. PATIENT'S BIRTH DATE    SEX <b>01</b> <b>01</b> <b>1980</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE JANE S</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>		CITY <b>ANYTOWN</b>			STATE <b>US</b>				
ZIP CODE <b>00001</b>		TELEPHONE (Include Area Code) (    )			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>0000001</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    SEX MM   DD   YY    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>CIGNA</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>					
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>												
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>03</b> <b>01</b> <b>21</b> QUAL.					15. OTHER DATE QUAL.    MM   DD   YY		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)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)    ICD Ind. <b>0</b>					22. RESUBMISSION CODE    ORIGINAL REF. NO.							
A. <b>M99.03</b>		B. <b>M99.04</b>		C. <b>M54.2</b>		D. _____		23. PRIOR AUTHORIZATION NUMBER				
E. _____		F. _____		G. _____		H. _____		20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
I. _____		J. _____		K. _____		L. _____		F. \$ CHARGES    G. DAYS OR UNITS    H. EPSCOT Family Plan    I. ID. QUAL.    J. RENDERING PROVIDER ID. #				
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>04 01 21 04 01 21</b>		<b>11</b>	<b>98940</b>	<b>AB</b>			<b>50 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>		
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97014</b>			<b>AB</b>	<b>35 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>		
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97012</b>			<b>AB</b>	<b>30 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>		
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
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<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
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<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
<b>04 01 21 04 01 21</b>		<b>11</b>	<b>97140</b>			<b>59</b>	<b>C</b>	<b>40 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>	
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