



HEALTH INSURANCE CLAIM FORM

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

HNS/ HTA
PO BOX 2368
CORNELIUS NC 28031

CARRIER

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/... 2. PATIENT'S NAME: DOE JOHN A 3. PATIENT'S BIRTH DATE: 01/01/1950 4. INSURED'S NAME: DOE JOHN A 5. PATIENT'S ADDRESS: 123 ANY STREET 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] 7. INSURED'S ADDRESS: 123 ANY STREET 8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER: HTA 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. ADDITIONAL CLAIM INFORMATION 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER 24. TABLE with columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSCOT Family Plan, I. ID. QUAL., J. RENDERING PROVIDER ID. # 25. FEDERAL TAX I.D. NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION