



HNS/MEDCOST
 PO BOX 2368
 CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

CARRIER

<input type="checkbox"/> PICA <input type="checkbox"/> PICA <input type="checkbox"/>																			
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) 000000001														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JANE S					3. PATIENT'S BIRTH DATE 01 / 01 / 1980 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JANE S												
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			8. RESERVED FOR NUCC USE		CITY ANYTOWN STATE US														
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. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 00001												
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE			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. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME MEDCOST			c. INSURANCE PLAN NAME OR PROGRAM NAME MEDCOST		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>												
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 _____ DATE _____														
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 03 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 _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M99.03 B. M99.04 C. M54.2 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					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/PCS E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSCOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #												
1		04 01 21		04 01 21		11		98940		AB		50 00		1		NPI		000000001	
2		04 01 21		04 01 21		11		97014		AB		35 00		1		NPI		000000001	
3		04 01 21		04 01 21		11		97012 GP		AB		30 00		1		NPI		000000001	
4		04 01 21		04 01 21		11		97140 59 GP		C		40 00		1		NPI		000000001	
5																NPI			
6																NPI			
25. FEDERAL TAX I.D. NUMBER 01-0000001 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 000001		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 155 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					33. BILLING PROVIDER INFO & PH # (001) 001-0001 JOHN Q CHIROPRACTOR DC PO BOX 000 ANYTOWN US 00001									
SIGNED _____ DATE _____					a. 0000000002		b. _____		a. 0000000002		b. _____								

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION