



HNS/SELECT HEALTH
PO BOX 2368
CORNELIUS NC 28031

HEALTH INSURANCE CLAIM FORM

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

CORRECTED CLAIM

PICA

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#)</small>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000000001	
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"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JOHN A
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	CITY ANYTOWN
ZIP CODE 00001	TELEPHONE (Include Area Code) ()	ZIP CODE 00001
TELEPHONE (Include Area Code) ()	8. RESERVED FOR NUCC USE	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 FIRST CHOICE VIP CARE
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 01 01 2000 M <input checked="" 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 FIRST CHOICE VIP CARE
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>
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) MM DD YY QUAL. 04 01 24
15. OTHER DATE MM DD YY QUAL. 17a. _____ 17b. NPI _____	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	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	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M99.01 B. M50.321 C. M99.02 ICD Ind. 0 E. M99.03 F. M54.50 G. _____ D. M51.34 I. _____ J. _____ K. _____ L. _____
22. RESUBMISSION CODE 7 ORIGINAL REF NO. CLAIM REF #	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/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSCOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #
1 04 05 24 04 05 24 11 98941 AT ACE 65 00 1 NPI 000000001	2 NPI	3 NPI
4 NPI	5 NPI	6 NPI
25. FEDERAL TAX I.D. NUMBER 00-0000000 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. DOE001	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
28. TOTAL CHARGE \$ 65 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.) JOE Q CHIROPRACTOR DC SIGNED _____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION CHIROPRACTIC OFFICE 123 ANY STREET ANYTOWN US 00001	33. BILLING PROVIDER INFO & PH # () CHIROPRACTIC OFFICE 123 ANY STREET ANYTOWN US 00001
a. 000000002	b. ZZ 111N00000X	a. 000000002 b. ZZ 111N00000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION