HNS/SELECT HEALTH
PO BOX 2368
CORNELIUS NC 28031

# HEALTH INSURANCE CLAIM FORM

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

PICA

## CORRECTED CLAIM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

| | |
|---|---|
| 1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#) | 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: 01 01 2000 SEX M [X] F [ ] |
| | 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 [X] Spouse [ ] Child [ ] Other [ ] |
| | 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): ( ) | 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: |
| | 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) YES [ ] NO [X] |
| | a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ] |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State) |
| | b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES [ ] NO [X] |
| | 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? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d. |
| **READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.** 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: 04 01 22 QUAL. | 15. OTHER DATE QUAL. MM DD YY |
| | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. 17b. NPI |
| | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0<br>A. M99.01 B. M99.02 C. M99.03 D.<br>E. F. G. H.<br>I. J. K. L. | 22. RESUBMISSION CODE 7 ORIGINAL REF. NO. Ref # most recently processed claim<br>23. PRIOR AUTHORIZATION NUMBER |

PHYSICIAN OR SUPPLIER INFORMATION

| 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. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 04 05 22 | 04 05 22 | 11 | | 98941 | AT | ABC | 50 00 | 1 | | NPI | 0000000001 |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. Rsvd for NUCC Use |
|---|---|---|---|---|---|
| 01-0000001 [ ] [X] | 0001 | [X] YES [ ] NO | $ 50 00 | $ | |

| 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.) | 32. SERVICE FACILITY LOCATION INFORMATION | 33. BILLING PROVIDER INFO & PH # ( 001 ) 001-0001 |
|---|---|---|
| JOHN Q CHIROPRACTOR DC | CHIROPRACTOR'S OFFICE<br>123 ANY STREET<br>ANYTOWN US 00001 | JOHN Q CHIROPRACTOR DC<br>PO BOX 000<br>ANYTOWN US 00001 |
| SIGNED DATE | a. 0000000002 b. | a. 0000000002 b. |