



HNS/SELECT HEALTH  
 PO BOX 2368  
 CORNELIUS NC 28031

**HEALTH INSURANCE CLAIM FORM**

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

CARRIER

<input type="checkbox"/> <input type="checkbox"/> PICA <span style="float:right">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 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>00000001</b>														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN A</b>					3. PATIENT'S BIRTH DATE MM DD YY    SEX <b>01 01 2000 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN A</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>FIRST CHOICE VIP CARE PLUS</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 MM DD YY    SEX 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>SELECT HEALTH</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>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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 _____					SIGNED _____ DATE _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY    QUAL. <b>04 01 2015</b>					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)										20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b>										22. RESUBMISSION CODE    ORIGINAL REF. NO.									
A. <b>739.1</b> B. <b>739.2</b> C. <b>739.3</b> 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/CS    MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #							
<b>04 05 15    04 05 15</b>		<b>11</b>	<b>98941</b>	<b>ABC</b>			<b>50 00</b>	<b>1</b>	<b>NPI</b>	<b>000000001</b>									
25. FEDERAL TAX I.D. NUMBER    SSN EIN <b>01-0000001</b> <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>0001</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>50 00</b>		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.) <b>JOHN Q CHIROPRACTOR DC</b>					32. SERVICE FACILITY LOCATION INFORMATION <b>CHIROPRACTOR OFFICE          123ANY STREET          ANYTOWN US 00001</b>					33. BILLING PROVIDER INFO & PH # (001) 001-0001 <b>JOHN Q CHIROPRACTOR          PO BOX 000          ANYTOWN US 00001</b>									
SIGNED _____ DATE _____					a. <b>0000000002</b> b.		a. <b>0000000002</b> b.												

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION