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 | 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
CITY: ANYTOWN STATE: US
ZIP CODE: 00001 TELEPHONE (Include Area Code): ( )

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 ABC STREET
CITY: ANYTOWN STATE: US
ZIP CODE: 00001 TELEPHONE (Include Area Code): ( )

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. OTHER ACCIDENT? YES [ ] NO [X]
10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: FIRST CHOICE VIP CARE PLUS
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME: SELECT HEALTH
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 ______

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 01 2015 QUAL.

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? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 739.1 B. 739.2 C. 739.3 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: Ref # most recently processed claim

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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 05 15	04 05 15	11		98941		ABC	50 00	1		NPI	0000000001
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 01-0000001 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 0001

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 50 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
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CHIROPRACTOR OFFICE
123ANY STREET
ANYTOWN US 00001
a. 0000000002 b.

33. BILLING PROVIDER INFO & PH # (001) 001-0001
JOHN Q CHIROPRACTOR
PO BOX 000
ANYTOWN US 00001
a. 0000000002 b.