



HNS/SELECT HEALTH  
 PO BOX 2368  
 CORNELIUS NC 28031

**HEALTH INSURANCE CLAIM FORM**

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

**CORRECTED CLAIM**

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																																																																															
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"/> <b>X</b> <input type="checkbox"/> <b>F</b>															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"/> <b>X</b> 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>					8. RESERVED FOR NUCC USE										CITY <b>ANYTOWN</b>										STATE <b>US</b>																																																						
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</b>																																																											
a. OTHER INSURED'S POLICY OR GROUP NUMBER															a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> <b>X</b> 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"/> <b>X</b> 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"/> <b>X</b> NO															c. INSURANCE PLAN NAME OR PROGRAM NAME <b>FIRST CHOICE</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"/> <b>X</b> NO 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.															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 _____															SIGNED _____																																																											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) <b>04 01 21</b> 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																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)															ICD Ind. <b>0</b>															22. RESUBMISSION CODE <b>7</b> ORIGINAL REF. NO. <b>Ref # most recently processed claim</b>																																																											
A. <b>M99.01</b>					B. <b>M99.02</b>					C. <b>M99.03</b>					D.					E.					23. PRIOR AUTHORIZATION NUMBER <b>00001 (req if under 18 yrs. old)</b>																																																																
E.					F.					G.					H.					I.					J.					F. \$ CHARGES															G. DAYS OR UNITS					H. EPSCDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #																													
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. EPSCDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #																													
<b>1</b> 04 05 21 04 05 21 11 98941 ABC 50 00 1 NPI 0000000001															<b>2</b> 04 05 21 04 05 21 11 72040 ABC 40 00 1 NPI 0000000001															<b>3</b>															<b>4</b>															<b>5</b>															<b>6</b>														
25. FEDERAL TAX I.D. NUMBER <b>01-0000001</b>										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/> <b>X</b>					26. PATIENT'S ACCOUNT NO. <b>0001</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> <b>X</b> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>90 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'S OFFICE          123 ANY STREET          ANYTOWN US 00001</b>															33. BILLING PROVIDER INFO & PH # <b>( 001 ) 001-0001</b> <b>JOHN Q CHIROPRACTOR DC          PO BOX 000          ANYTOWN US 00001</b>																																																											
SIGNED _____															DATE _____															a. <b>0000000002</b>					b.					a. <b>0000000002</b>					b.																																												

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION