# HEALTH INSURANCE CLAIM FORM

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

HNS/SELECT HEALTH
PO BOX 2368
CORNELIUS NC 28031

CARRIER

PICA ☐☐☐ PICA ☐☐☐

| 1. MEDICARE ☐ (Medicare#) | MEDICAID ☐ (Medicaid#) | TRICARE ☐ (ID#/DoD#) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (ID#) | FECA BLK LUNG ☐ (ID#) | OTHER ☐ (ID#) |
|---|---|---|---|---|---|---|

**PATIENT AND INSURED INFORMATION**

| 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 [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 / STATE | ANYTOWN / US |
| 8. RESERVED FOR NUCC USE | |
| CITY / STATE | ANYTOWN / US |
| ZIP CODE / TELEPHONE (Include Area Code) | 00001 / ( ) |
| 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 NEXT |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | |
| a. EMPLOYMENT? (Current or Previous) | [ ] YES [X] NO |
| a. INSURED'S DATE OF BIRTH MM DD YY / SEX | 01 01 2000 M [X] F [ ] |
| b. RESERVED FOR NUCC USE | |
| b. AUTO ACCIDENT? PLACE (State) | [ ] YES [X] NO |
| b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | |
| c. OTHER ACCIDENT? | [ ] YES [X] NO |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | FIRST CHOICE NEXT |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | |
| 10d. CLAIM CODES (Designated by NUCC) | |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | [ ] YES [X] 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.

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 QUAL. MM DD YY | |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | |
| 17a. | |
| 17b. NPI | |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | |
| 20. OUTSIDE LAB? $ CHARGES | [ ] YES [ ] NO |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. | 0 |
| A. | M99.01 |
| B. | M50.321 |
| C. | M99.02 |
| D. | M51.34 |
| E. | M99.03 |
| F. | M54.50 |
| G. | |
| H. | |
| I. | |
| J. | |
| K. | |
| L. | |
| 22. RESUBMISSION CODE / ORIGINAL REF. NO. | |
| 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 24 / 04 05 24 | 11 | | 98941 | AT | ACE | 65 00 | 1 | | ZZ 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 |
|---|---|---|---|---|---|---|
| 00-0000000 | [ ] [X] | DOE001 | [X] YES [ ] NO | $ 65 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 # ( ) |
|---|---|---|
| JOE Q CHIROPRACTOR DC | CHIROPRACTIC OFFICE<br>123 ANY STREET<br>ANYTOWN US 00001 | CHIROPRACTIC OFFICE<br>123 ANY STREET<br>ANYTOWN US 00001 |
| SIGNED DATE | a. 0000000002 b. | a. 0000000002 b. ZZ 111N00000X |

NUCC Instruction Manual available at: www.nucc.org

**PLEASE PRINT OR TYPE**

APPROVED OMB-0938-1197 FORM 1500 (02-12)