1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | 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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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									NPI	
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) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CMS 1500 Claim Form			
Decision Point	**Locator**	**Description**	**Comments**
Membership Verification	1a	Insured's ID Number	ID number identifying the patient in the claims processing system.
	2	Patient Name	Last name first.
	3	Patient Date of Birth Sex (M F)	Used to verify the correct patient especially if members have the same names.
	5	Patient Address	Street address and telephone number (telephone numbers are not always available).
	4	Insured's Name	The name of the person who is the subscriber. May be the patient or the patient's spouse or parent.
	7	Insured's Address	Street address and telephone number (telephone numbers are not always available).
	6	Patient Relationship to Insured	Check box to indicate if the patient is the subscriber (Self) or a dependent (Spouse or Child). "Other" is rarely if ever checked.
	8	Patient Status	Check boxes indicating marital, employment, and student status.
	11	Insured's Policy Group or FECA number	The group ID number that identifies the patient's health plan.
	11a	Insured's date of birth Sex (M F)	Used to verify the correct insured especially if members have the same names.
	11b	Employer's Name or School Name	Used to verify the correct insured; name of employer should match the group ID number. If the patient is a student, the name of the school is useful to verify student status.
	11c	Insurance Plan Name	Used to verify the correct insured; name of plan should correspond to the group ID number.
Provider Verification	24J	Rendering Provider ID#	The National Provider ID (NPI) for the specific physician or other provider who rendered the specified service.
	25	Federal Tax ID Number	The US federal tax identification number of the provider. Can be a Social Security number (SSN) for a solo practitioner or an Employer Identification Number (EIN) for a group practice or business entity.
	31	Signature	Usually displayed is the individual physician who provided the service or supervised others in providing the service.
	33	Billing Provider Info & Phone Number	Name and billing address of the provider of service. Some physicians work in multiple offices. A separate provider record is usually established for each office so that payment is sent to the correct address. Both name and address must be verified in order to link the claim to the correct provider.
Duplicate Checking	1a	Insured's ID Number	Although the duplicate checking logic varies in claims processing systems, most logic depends on analyzing the combination of member ID, provider ID, dates of service, and sometimes procedure code to ascertain if a specific charge is already on file in the system.
	24J	Rendering Provider ID#	
	25	Provider Federal Tax ID Number	
	24A	Date(s) of Service	
	24D	Procedure Code	
Benefit Determination	21	Diagnosis Code(s)	IDC9-CM Diagnosis Code. At least one code must be listed. Must include at least 4 digits.
	24A	Dates of Service	The specific date(s) when the service took place. Cannot be a future date.
	24B	Place of Service	A 2-digit code indicating where a service took place

CMS 1500 Claim Form			
Decision Point	**Locator**	**Description**	**Comments**
			(doctor's office, inpatient, outpatient, ER, etc.).
	24D	Procedures, Services, Supplies	A 5-digit CPT4 or HCPCS code indicating the specific procedure, service or supply. May be followed by a 2-digit Modifier code.
	24E	Diagnosis Pointer	The number 1, 2, 3, and/or 4 indicating which diagnosis code is linked to the procedure.
	24J	Rendering Provider ID#	Benefits may be affected by the provider's participating status in the patient's health plan.
Authorizations/ Referrals	24J 25	Rendering Provider ID# Provider Federal Tax ID Number	At least one Provider ID number must match the provider ID on the authorization record in the processing system.
	23	Prior Authorization Number	If a prior authorization number is listed by the provider, it must be verified.
	24A	Dates of Service	The specific date(s) when the service took place must match the dates on the authorization on file in the processing system.
Provider Payment Terms	24A	Dates of Service	The specific date(s) when the service took place. Cannot be a future date.
	24D	Procedures, Services, Supplies	A 5-digit CPT4 or HCPCS code indicating the specific procedure, service or supply. May be followed by a 2-digit Modifier code.
	24F	Charges	The amount the provider bills for the procedure.
	24G	Days or Units	The number of procedures, services, or supplies being billed.
Other Party Liability	8	Patient Status	The combination of boxes that are checked may indicated potential COB. Example: Patient is a spouse who is married and employed and therefore, may have other health insurance.
	9	Other Insured's Name	Usually indicates a spouse's name who has other health insurance.
	9a	Other Insured's Policy or Group Number	The ID number of the other health insurance plan.
	9b	Other Insured's Date of Birth	Usually indicates a spouse's date of birth to verify coverage with another health plan.
	9c	Employer's Name or School Name	Usually indicates a spouse's employer. Could also show a school name if patient is a student.
	9d	Insurance Plan Name or Program Name	The name of the other health plan.
	10	Patient's Condition Related To	May indicate an injury associated with an auto or workplace accident.
	11d	Is There Another Health Benefit Plan	Yes or No check box