HEALTH INSURANCE CLAIM FORM (CMS-1500) (02-12)

Form HCFA-1500 / CMS-1500 • OMB APPROVED — Approved by National Uniform Claim Committee (NUCC)

1. INSURANCE TYPE	1a. INSURED'S ID NUMBER	PAYER NAME / ADDRESS
MEDICARE	W123456789	ACME HEALTH PLAN 123 PAYER WAY ANYTOWN, ST 00000

2. PATIENT'S NAME (Last, First, MI)	3. PATIENT'S BIRTH DATE	SEX
PUBLIC, JANE Q	1981-05-14	F

4. INSURED'S NAME (Last, First, MI)	5. PATIENT ADDRESS
PUBLIC, JANE Q	101 MAIN ST ANYTOWN, ST 00000

6. PATIENT RELATIONSHIP TO INSURED	7. INSURED ADDRESS
SELF	101 MAIN ST ANYTOWN, ST 00000

14. DATE OF CURRENT ILLNESS (LMP)	15. OTHER DATE	17. REFERRING PROVIDER
2025-08-01		DR. GOODCARE • NPI 1234567890

21. DIAGNOSIS OR NATURE OF ILLNESS (ICD) — A-L

A: M54.5 B: J06.9 C: R51.9 D: Z00.00 E: E11.9 F: I10
G: Z23 H: R05.1 I: R50.9 J: R10.9
K: Z79.899 L: Z13.89

24. A — J SERVICE LINES (From/To Date, POS, EMG, CPT/HCPCS, MOD, Charges, Units, NPI)

From	To	POS	EMG	CPT/HCPCS+MOD	Charges	Units	NPI
2025-08-01	2025-08-01	11	N	99213 25	$150.00	1	1234567890
2025-08-01	2025-08-01	11	N	81002	$20.00	1	1234567890
2025-08-01	2025-08-01	11	N	90686	$30.00	1	1234567890

25. FEDERAL TAX ID / SSN	28. TOTAL CHARGE	29. AMOUNT PAID
12-3456789	$200.00	$0.00

NOTE: This simplified sample is for testing classification only. Not an official billing document.