1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): JS00111223333

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

3. PATIENT'S BIRTH DATE MM DD YY: 05 01 73 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 236 N MAIN ST

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

7. INSURED'S ADDRESS (No., Street): 123 TEST STREET

CITY: MIAMI STATE: FL

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: AUSTIN STATE: TX

ZIP CODE: 33413 TELEPHONE (Include Area Code): ( )

ZIP CODE: 78701 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: 2222-SJ

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 05 01 43 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: KEY INSURANCE COMPANY

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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 Signature on file

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 [X] $ CHARGES

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

1. 034.0
2. V73.89
3.
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	10	03	06	10	03	06	13	Y	99213	AA BB CC DD	1	40 00	1		PXC	1G1000X
															NPI	1234567890
2	10	03	06	10	03	06	11		87070		123	15 00	1		1G	12345
															NPI	3456789012
3	10	10	06	10	10	06	11		99214		2	35 00	1		PXC	1G1000X
															NPI	1234567890
4	10	10	06	10	10	06	11		86663		2	10 00	1		PXC	1G1000X
															NPI	1234567890
5	10	03	06	10	03	06	11		99213		1	40 00	1		PXC	1G1000X
															NPI	1234567890
6	10	03	06	10	03	06	11		87070		1	15 00	1		PXC	1G1000X
															NPI	1234567890

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 587654321 [X]

26. PATIENT'S ACCOUNT NO.: 26463774

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

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $ 10 00

30. BALANCE DUE: $ 90 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.)

PROVIDER SIGNATURE IS ON FILE

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

SERVICE FACILITY ABC
STREET ABC
CITY, ST 12345

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # ( )

BEN KILDARE SERVICE
234 SEAWAY ST
MIAMI, FL 33111

a. 9876543210 b.

NUCC Instruction Manual available at: www.nucc.org

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

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													NPI	1234567890
2													NPI	
3													NPI	
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