Revised CMS-1500 Health Insurance Claim Form (08/05)

Changes in blue • Source of changes: www.nucc.org/images/stories/PDF/final_1500_change_log.pdf

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

HEALTH ADVANTAGE, INC
PO BOX 1511
FLINT, MI 48501-1511

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [ ] TRICARE CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [X] FECA BLK LUNG [ ] OTHER [ ]	1a. INSURED'S I.D. NUMBER: 555-55-0055
2. PATIENT'S NAME: Smith, Ann G	3. PATIENT'S BIRTH DATE: 06 15 55 SEX: M [ ] F [X]
4. INSURED'S NAME: Smith, Ann G	
5. PATIENT'S ADDRESS: 1234 Anywhere Ave	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS: 1234 Anywhere Ave	
CITY: Okemos STATE: MI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: Okemos STATE: MI	
ZIP CODE: 48864 TELEPHONE: (517) 555-5555	ZIP CODE: 48864 TELEPHONE: ( )
9. OTHER INSURED'S NAME:	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ] b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State) c. OTHER ACCIDENT? YES [ ] NO [ ]
11. INSURED'S POLICY GROUP OR FECA NUMBER: BCCCP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. INSURED'S DATE OF BIRTH: 06 15 55 SEX: M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME:
c. EMPLOYER'S NAME OR SCHOOL NAME:	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: SIGNATURE ON FILE 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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI 1346269644	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. V72.31 2. 3. 4.	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	03 06 07		11		99213			77.00	1		NPI	382853534 1346269644
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 382853534 SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 1234500	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 77.00	29. AMOUNT PAID: $ 00	30. BALANCE DUE: $ 77.00

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.)
RICHARD, ROBERT
Signed 08/27/2007 Date

32. SERVICE FACILITY LOCATION INFORMATION
WESTSIDE HEALTH CENTER
669 STOCKING NW
GRAND RAPIDS, MI 49504
a. 1891867495 b.

33. BILLING PROVIDER INFO & PH #
CHERRY STREET HEALTH SVC
101 SHLDON BLVD, STE 1
GRAND RAPIDS, MI 49503
a. 1558459164 b. 3828535340

NUCC Instruction Manual available at: www.nucc.org

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