Sample
CMS-1500 Form

STERLING Option I®
P.O. Box 69314
Harrisburg, PA
17106-9314

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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): 555-55-5555A
2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Bob A.	3 PATIENT'S BIRTH DATE MM DD YY: 12 18 36 SEX M [ ] F [X]
4 INSURED'S NAME (Last Name, First Name, Middle Initial): Same	
5 PATIENT'S ADDRESS (No., Street): 123 Paradise Road	6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7 INSURED'S ADDRESS (No., Street): Same	
CITY: Seattle STATE: WA	8 PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY: STATE:	
ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
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: None	
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 SEX M [ ] F [ ]	
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	
d INSURANCE PLAN NAME OR PROGRAM NAME	d 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 02/14/2006

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: 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: K. Brown, MD	17a. A55555 17b. NPI 1234567890
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. 250.00 2. V58.61 3. 4.	22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23 PRIOR AUTHORIZATION NUMBER: 50D0000000

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 02 05 06	02 05 06	11		99212		1, 2	55 00	1		NPI	3322221111
2 02 05 06	02 05 06	11		85610		1, 2	30 00	1		NPI	3322221111
3 02 05 06	02 05 06	11		85635		1, 2	30 00	1		NPI	3322221111
4										NPI	
5										NPI	
6										NPI	

25 FEDERAL TAX I.D. NUMBER: 99-1234567 SSN [ ] EIN [X]	26 PATIENT'S ACCOUNT NO.: 12345987	27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28 TOTAL CHARGE: $ 115 00	29 AMOUNT PAID: $	30 BALANCE DUE: $ 115 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 # (555) 555-5555
T. Jones	Office Name 123 Main St. Seattle, WA 12345-2345	Provider Name P.O. Box 12345 Seattle, WA 12345-2345
SIGNED 02/14/06 DATE	a. 1123456789 b.	a. 1111222233 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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