1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

R Required - claim block must be completed
A Applicable - claim block must be completed, if applicable
O Optional - claim block is optional
LB Leave Blank - claim block should be left blank

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 (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

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

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.

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)

SAMPLE

DOC 1500

Blk No.	Block Descritpion
1	**Type of Claim** LB Do not complete this block
1a	**Insured's ID Number** R Enter the Member's ID, Must be 8 Characters. Note: Include any leading zeros.
2	**Patient's Name** R Patient Last Name and First name (e.g., Doe, John) Submit utilizing exact name provided on ID card (HC Only)
3	**Patient's Birthdate and Sex** R Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578). Indicate the patient's gender by placing an X in the appropriate box.
4	**Insured's Name** R Beneficiary's Last Name and First name (e.g., Doe, John) Submit utilizing exact name provided on ID card
5	**Patient's Address** R Enter the patient's address
6	**Patient's Relationship to the Insured** R Enter an "X" in the appropriate box. Select only one.
7	**Insured's Address** R Enter Beneficiary's Address
8	**Patient Status** LB Do not complete this block
9	**Other Insured's Name** A If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured.
9a	**Other Insured's Policy and Group Number** A If Applicable, enter Other insured's Policy and Group Number of Insured's name in Block 9.
9b	**Other Insured's Date of Birth and Sex** A If Applicable, enter Other Insured's date of birth and Sex of Insured's name in Block 9. Enter date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578). Indicate Other Insured's gender by placing an X in the appropriate box.
9c	**Employer's Name or School Name** A If Applicable, enter Employer's Name or School Name of Other Insured's name in Block 9
9d	**Insurance Plan Name or Group Name** LB If Applicable, enter Insurance Plan Name or Group Name of Other Insured's name in Block 9
10a-10c	**Is Patient's Condition Related To:** A Complete the block by placing an X in the appropriate YES or NO box to indicate whether the patient's condition is related to employment or auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. Do not complete state box field
10d	**Reserved For Local Use** O Enter a "C" for a corrected claim in this field.
11	**Insured's Policy Group or FECA Number** LB Enter the policy number and group number of the primary insurance
11a	**Insured's Date of Birth and Sex** R Enter Beneficiary's date of birth and Sex of Insured's name in Block 11. Enter date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578). Indicate the Beneficiary's gender by placing an X in the appropriate box.
11b	**Employer's Name or School Name** R Enter the name of the Beneficiary's employer for the primary insurance
11c	**Insurance Plan Name or Program Name** R List the name and address of the primary insurance listed in Block 11.
11d	**Is There Another Health Benefit Plan?** R Place an X in the appropriate box. If yes, complete Blocks 9 (a-d)
12	**Patient's or Authorized Person's Signature and Date** R Enter patients or authorized person's signature. Enter date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578).
13	**Insured's or Authorized Person's Signature** R Enter Beneficiary's or authorized person's signature. Enter date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578).
14	**Date of Current:** O If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, year) format (e.g., 030104).
15	**If Patient Has Had Same or Similar Illness** A If the patient had the same or similar illness list first date of occurrence in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, year) format (e.g., 030104).
16	**Dates Patient Unable to Work in Current Occupation** A If completed enter the FROM and TO dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, year) format (e.g., 030104).
17a	**Name of Referring Physician or Other Source** A Enter name of the Referring Physician or other source such as a clinic or facility.
17b	**NPI of Referring Physician or Other Source** LB Enter the National provider Identifier (NPI) number of name entered in Block 17a.
18	**Hospitalization Dates related to current services** A When the serving/billing provider's services charged on this claim are related to a patient's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Date should be in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, and year) format (e.g., 030104).
19	**Reserved For Local Use** LB Do not complete this block

Blk No.	Block Descritpion
20	**Outside Lab?** LB Do not complete this block.
21	**Diagnosis or Nature of Illness or Injury** R Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. The primary ICD-9-CM code (21.1) must be completed.
22	**Medicaid Resubmission** LB Do not complete this block.
23	**Prior Authorization Number** R Enter the Prior Authorization Number.
24a	**Dates of Service** R Enter the applicable date(s) of service in an 8-digit format. If billing for a service that was provided on one day only, complete the From date of service only. If the same service was provided on consecutive days, enter the first day of the service in the From column and the last day of service in the To column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g., 03012004) or a six-digit format (MMDDYY) to record From and To dates (e.g., 030104). If the dates are not consecutive, separate claim lines must be used.
24b	**Place of Service** R Enter the 2-digit national standard place of service code that indicates where the service was performed. Examples: 11—Office, 22—Hospital, 23—ECF, 99—Other
24c	**EMG** A Enter "Y" if the service provided was in response to an emergency, otherwise, leave this block blank.
24d	**Procedures, Services, or Supplies (CPT/HCPCS & Modifier)** R/AAAA List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to 3 additional informational modifier's when applicable. If no pricing modifier is required, enter up to 4 additional/informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.
24e	**Diagnosis Pointer** R This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 2.1), enter 1. If provided for the secondary diagnosis, enter 2. If provided for the third diagnosis, enter 3, and for the fourth diagnosis, enter 4
24f	**$Charges** R Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter 6500.
24g	**Days or Units** R Enter the number of units, services, or items provided. Can enter decimal (e.g., 5.1) but cannot be more than 8 digits. For anesthesia/CRNA, please provide minutes only.
24h	**EPSDT/Family Planning** LB Do not complete this block.
24i	**ID Qualifier** LB Do not complete this block.
24j (a)	**Rendering Provider ID # (shaded)** LB Do not complete this block.
24j (b)	**NPI (not shaded)** R Enter the ten digit NPI number of the rendering provider.
25	**Federal Tax I.D. Number** R Enter Federal tax number of the entity to whom payment is expected to be issued to and place an X in the appropriate block. Cannot be greater than nine digits
26	**Patient's Account Number** O Use of this block is strongly recommended. It can contain up to 20 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name.
27	**Accept Assignment?** R Must put an "X" in either the "yes" box or the "no" box but not in both.
28	**Total Charge** R Total charges of all details on the claim. Total charge must be greater than zero. Format example, if total charge is sixty-five dollars, enter 6500. Multiple page claims are not allowed. If detail requires more than one claim, each claim must be considered a separate claim with its own total charge.
29	**Amount Paid** O Patient payment at time of visit. If entered must be numeric. For example if amount paid is sixty-five dollars, enter 6500.
30	**Balance Due** R From the total charge, subtract amounts received from other sources and enter the result.
31	**Signature of Physician or Supplier Including Degree or Credentials** R The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction
32	**Service Facility Location Information** R Enter name and address where service was performed. Zip code must be nine digits (e.g., 770513246).
32a	R Enter the National Provider Identifier (NPI) number of the Service Facility Location.
32b	R Enter the PIN# supplied on HealthChoice portal.
33	**Billing Provider Info & Ph.#** R Enter name and address. Zip code must be nine digits (e.g. 770513246).
33a	R Enter the ten digit NPI number of the billing provider
33b	LB Do not complete this block.

LEGEND: R – Required A – Applicable O – Optional LB – Leave Blank