

HEALTH INSURANCE CLAIM FORM

SAMPLE CMS 1500 FORM INITIAL OR SUBSEQUENT CLAIM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER 1a. INSURED'S I.D. NUMBER 123-45-6789A 2. PATIENT'S NAME SMITH, JOHN Q. 3. PATIENT'S BIRTH DATE 08/15/31 SEX M 4. INSURED'S NAME SMITH, JOHN Q. 5. PATIENT'S ADDRESS 543 MADISON STREET 6. PATIENT RELATIONSHIP TO INSURED Self 7. INSURED'S ADDRESS 543 MADISON STREET 8. PATIENT STATUS Single 9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Select appropriate modifier with J0885. For more information, click here.

14. DATE OF CURRENT: 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY OR PREGNANCY(LMP) GIVE FIRST DATE 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI 19. RESERVED FOR LOCAL USE HCT or Hb level. Other documentation must be available upon request. 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER

Table with columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL, J. RENDERING PROVIDER ID. #. Includes rows for J0885 and 96372 or 96374.

Note: Payments for a Level 1 E/M code and injection code are bundled when billed together on the same date of service. This document is presented for informational purposes only and is not intended to provide reimbursement or legal advice.

25. FEDERAL TAX I.D. NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

SIGNED DATE a. NPI b. NPI UPDATE 2/21/11

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION