



1. CMS Form 1500 "Health Insurance Claim Form"

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE					2. CHAMPVA		3. GROUP HEALTH PLAN		4. FECA BLK/LUNG	5. OTHER		
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) Enter Patient's Social Security Number												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)				
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE		
ZIP CODE		TELEPHONE (Include Area Code) ()			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			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 N/A if Medicare only (no other insurance)		
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					SEX M <input type="checkbox"/> F <input type="checkbox"/>		
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME					10g. RESERVED FOR LOCAL USE					c. INSURANCE PLAN NAME OR PROGRAM NAME		
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.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
SIGNED _____ DATE _____					SIGNED _____ DATE _____							
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Enter name of referring physician					17a. I.D. NUMBER OF REFERRING PHYSICIAN Enter UPIN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO Leave Blank					22. MEDICAID RESUBMISSION CODE Leave Blank ORIGINAL REF. NO.		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER Leave Blank							
1. Enter ICD-9 Code (###.###)					3. Enter ICD-9 Code (###.###)							
2. Enter ICD-9 Code (###.###)					4. Enter ICD-9 Code (###.###)							
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR Family Plan	H EPSDT	I EMG	J COB	K RESERVED FOR LOCAL USE
1		22		Complete this section			Enter number of days				Enter performing provider PIN	
2												
3												
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER			SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) PO Box not acceptable				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Enter physician or supplier's billing name, address, zip code and phone number PIN# Enter PIN GRP# Enter Group #				
SIGNED _____ DATE _____												

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM CWCP-1500, APPROVED OMB-0720-0001 (CHAMPVA)