CMS 1500 - Interactive

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

- Cyan indicates a Required field that must be completed. Otherwise, claim processing may be delayed or claim may be returned to provider.
- Green indicates a Conditionally Required field that must be completed when a particular condition is present. Otherwise, claim processing may be delayed or the claim returned.
- Yellow indicates an Optional field; information is helpful but not necessary.
- Grey indicates an N/A field that is not applicable to HMSA claims processing.
- * Asterisk indicates field for which input error is relatively frequent. Take extra care when completing the field.

CARRIER

PICA

PICA

EDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

NSURED'S I.D. NUMBER (For Program in Item 1)

NAME (Last Name, First Name, Middle Initial)

ATIENT'S BIRTH DATE MM DD YY | SEX M F

SURED'S NAME (Last Name, First Name, Middle Initial)

TIENT'S ADDRESS (No., Street)

IENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

URED'S ADDRESS (No., Street)

CITY | STATE

IENT STATUS Single | Married | Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code) ( )

HER INSURED'S NAME (Last Name, First Name, Middle Initial)

PATIENT'S CONDITION RELATED TO:

SURED'S POLICY GROUP OR FECA NUMBER

HER INSURED'S POLICY OR GROUP NUMBER

PLOYMENT? (Current or Previous) YES | NO

URED'S DATE OF BIRTH MM DD YY | SEX M F

HER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

O ACCIDENT? YES | NO | PLACE (State)

PLOYER'S NAME OR SCHOOL NAME

PLOYER'S NAME OR SCHOOL NAME

HER ACCIDENT? YES | NO

URANCE PLAN NAME OR PROGRAM NAME

URANCE PLAN NAME OR PROGRAM NAME

ESERVED FOR LOCAL USE

HERE 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.

TIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary rocess this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize yment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____ DATE _____

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

PATIENT HAS HAD SAME OR SIMILAR ILLNESS. VE FIRST DATE MM DD YY

TES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | MM DD YY TO

ME OF REFERRING PROVIDER OR OTHER SOURCE

NPI

SPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | MM DD YY TO

ESERVED FOR LOCAL USE

UTSIDE LAB? YES | NO | $ CHARGES

AGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

EDICAID RESUBMISSION ODE | ORIGINAL REF. NO.

1. _____ . _____ 3. _____ . _____

IOR AUTHORIZATION NUMBER

2. _____ . _____ 4. _____ . _____

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PL SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAG POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J REN PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

DERAL TAX I.D. NUMBER SSN EIN

TIENT'S ACCOUNT NO.

CEPT ASSIGNMENT? govt. claims, see back YES | NO

TAL CHARGE $

OUNT PAID $

ALANCE DUE $

GNATURE OF PHYSICIAN OR SUPPLIER CLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

ERVICE FACILITY LOCATION INFORMATION

NPI

LLING PROVIDER INFO & PH # ( )

NPI

NUCC Instruction Manual available at: www.nucc.org

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