1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

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

COB Information,
T=Payment C0:45= Contractual write off,
PR:01=Patient Responsibility:
Line Level Report.

Claim Level Report
If Box 30 is not equal to Pt Responsibility you must Report Pt Responsibility in Box 19.

17a Enter Qualifier 1D with Medicaid ID Number. After May 22, 2007, Taxonomy Code with a ZZ Qualifier if Applicable.
17b: NPI of Referring Provider.

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 ZZ 123400000X

17b. NPI 1234567891

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

19. RESERVED FOR LOCAL USE

PR:01:100.00

20. OUTSIDE YES

21. DIAGNOSIS OR NATURE OF ILLN

1. ____ . ____

2. ____ . ____

22. MEDICAL CODE

23. PRIOR A

Medicaid Requires NDC # for Drugs Administered in Physician's office. NDC Code is placed in shaded area, along with Qualifier of Milliliters (ML), Units (UN) Grams (GR), Milligrams (MG), and Unit Price. HCPCS J-CODE is then placed in un-shaded area with price and amount given.

24J: Medicaid ID Number of Rendering Physician in shaded area. After May 22, 2007, Taxonomy Number with ZZ Qualifier, If Applicable.
24J: Un-shade area, Rendering Provider NPI.

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. #
T:400 PR:01 100 CO:45: 50		E		60574411201 J code			275.00 550.00	UN 2		ZZ NPI	123400000X 1234567891
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

33a: NPI for Billing Provider 33b: Medicaid Provider Number, with 1D qualifier, after May 22, 2007, Taxonomy Number with ZZ qualifier. If Applicable.

33. Billing Provider Name, Address, Zip Code. (This is who receives reimbursement.) If billing in a group this would be the group name. (If NPI is <u>not</u> one to one match to Medicaid Contract Number, system will look at Service Address to match the Medicaid Contract Address.)

25. ... MENT? back) NO

28. TOTAL CHARGE $ 550.00

29. AMOUNT PAID $ 400.00

30. BALANCE DUE $ 150.00

31. ...

33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE

a. NPI b.

a. 1234567891 b. 1D546223461001

NUCC Instruction Manual available at: www.nucc.org

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