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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

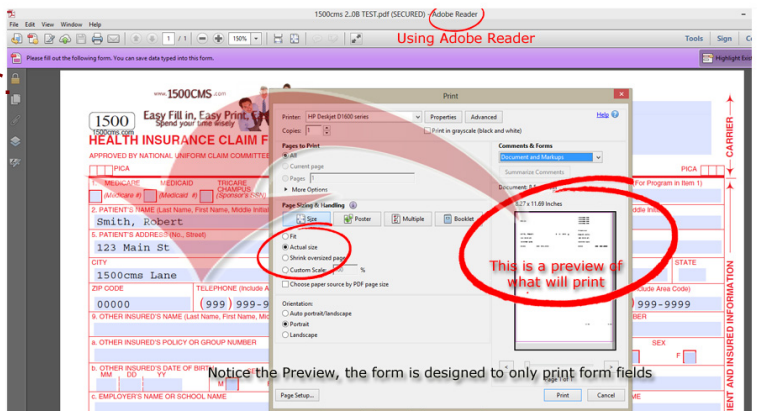
<input type="checkbox"/> <input type="checkbox"/> PICA		PICA <input type="checkbox"/> <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	
		SEX <input type="checkbox"/> M <input type="checkbox"/> F	
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"/>	
CITY		STATE	
ZIP CODE		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDI	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Curr	
		<input type="checkbox"/> YES	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	
		<input type="checkbox"/> YES	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	
		<input type="checkbox"/> YES	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Des	

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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.				13. I HEREBY CERTIFY THAT I HAVE RECEIVED PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.			
SIGNED _____ DATE _____				SIGNED _____			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER 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 PROVIDER OR OTHER SOURCE		17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
		17b. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____			
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	
25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd. for NUCC Use			
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. SERVICE FACILITY LOCATION INFORMATION			
33. BILLING PROVIDER INFO & PH #							

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2
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PHYSICIAN OR SUPPLIER INFORMATION

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