

Sample CMS 1500 Claim Form For Professional Billing



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA		PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)	
TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN)	
OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE		7. INSURED'S ADDRESS (No., Street) CITY STATE	
ZIP CODE TELEPHONE (Include Area Code) ()		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: <input type="checkbox"/> NO <input type="checkbox"/> YES	
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. SIGNED _____ DATE _____		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	

CARRIER
PATIENT AND INSURED INFORMATION

Field 21: Diagnosis or Nature of Illness or Injury
Enter the ICD-9-CM code that best describes the reason for treatment. For example, a code for PTCL may be selected from the 202.7x series of ICD-9-CM codes.

Field 19: Reserved for Local Use
For Medicare patients, enter the name of the drug and the amount of drug used to treat the patient. An NDC code is acceptable but not required. Other payors may require this information in different places or different formats on the CMS-1500 claim form.

Field 24D: Procedures, Services or Supplies
Enter J9999 (not otherwise classified, antineoplastic drug).
On separate line(s), enter CPT codes that best describe chemotherapy administration and other services provided on the same date of service. For example, CPT code 96409 describes the intravenous chemotherapy administration via IV push of a single or initial drug.

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT GIVE FIRST	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
19. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 1)	
24. A. DATE(S) OF SERVICE From MM DD To MM DD		B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual CPT/HCPCS)	
1			
2			
3			
4			
5			
6			

For claims submitted electronically, the above information should be entered in the Loop and Segment fields that cross-walk to the Fields indicated above. A cross-walk of the CMS-1500 claim form to the X12 837 Health Care Claim: Professional Version 4010A1 electronic transaction can be found on the Web site of the National Uniform Claim Committee at http://www.nucc.org/images/stories/PDF/1500_form_map_to_837p_4010a1_v1-0_112008.pdf