

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1 2 3

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FOLD HERE / USE ENVELOPE NO. 1500E

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare #)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
MEDICAID <input type="checkbox"/> (Medicaid #)										2. PATIENT'S NAME (Last Name, First Name, Middle Initial)																													
TRICARE <input type="checkbox"/> (Sponsor's SSN)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																													
CHAMPVA <input type="checkbox"/> (Member ID#)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																													
GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)										5. PATIENT'S ADDRESS (No., Street)																													
FECA BLK LUNG <input type="checkbox"/> (SSN)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																													
OTHER <input type="checkbox"/> (ID)										7. INSURED'S ADDRESS (No., Street)																													
CITY					STATE					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 <input type="checkbox"/> NO <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.																			
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. SIGNED _____ DATE _____																				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 _____																			
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 PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
										17b. NPI _____																													
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ 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 _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY																			
1. _____										3. _____										B. PLACE OF SERVICE _____																			
2. _____										4. _____										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. # _____																			
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) YES <input type="checkbox"/> NO <input type="checkbox"/>																			
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. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																			
SIGNED _____ DATE _____										a. NPI _____					b. _____					a. NPI _____					b. _____														