

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AMA       DB       AMA       DB       AMA       DB       A         PATIENT FEALTOCOME TO MEMORE       A PATIENT FEALTOCOME TO MEMORE       A ROUNED'S ADDRESS (No. Street)       A         PT       State       B ANTENT FEALTOCOME TO MEMORE       GTTY       STATE         PCOPE       TELEPHONE (INCUSA AND COOL)       Employed       State       B ANTENT FEALTOCOME TO MEMORE       GTTY       STATE         PCOPE       TELEPHONE (INCUSA AND COOL)       Employed       State       B ANTENT FEALTOCOME       GTTY       STATE         OTHER INSURED'S POLICY ON GOLDO NUMBER       B. LINE/DATALITY (Currer of Procesca)       B. NUMPETO PATIENT FEALTOCOME       B. NUMPETO PATIENT FEALTOCOME       B. NUMPETO PATIENT FEALTOCOME         DITER INSURED'S POLICY ON GOLDO NUMBER       S. LINE/DATALITY (Currer of Procesca)       B. NUMPETO PATIENT FEALTOCOME       B. NUMPETO PATIENT FEALTOCOME       B. NUMPETO PATIENT FEALTOCOME         NUMPETO PEANTER OF RESTORME ANALE       CONCERNANCE OF RODORNI NAME       CON	PICA			PICA
Jakebare 20         Jobson 20	MEDICARE MEDICAID TRICARE CHA		1a. INSURED'S I.D. NUMBER (For Program ir	n Item 1)
PATIENT'S ALDERES (No. Sincer)         Image: Construction of the second se	(Medicare #) (Medicaid #) (Sponsor's SSN) (Merr	ber ID#) $(SSN \text{ or } ID)$ $(SSN)$ $(ID)$		
PATERITS ADDRESS (No Street) <ul> <li>PATERITS ADDRESS (No Street)</li> <l< td=""><td>. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td><td></td><td>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</td><td></td></l<></ul>	. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
State         Bandle Sposse         ONE         OTH         STATE	PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
YY         ITALE         IT				
P CODE TELEPHONE (Incute Area Code) P CODE TELEPHONE (Incute Area	ST/		CITY S	STATE
		Single Married Other		
	IP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Co	ode)
CTHER INSURED'S POLICY OR GROUP NUMBER  CTHER INSURED'S DATE OF BITTY  SC  DATE OF DISTRICT PARAME OR SCHOOL NAME  COTHER ACDERNY PACE (BRM)  D AUTO ACCIDENY PACE (BRM) COTHER SAME OR SCHOOL NAME  COTHER ACDERNY COTHER INSURANCE OR SCHOOL NAME  COTHER INSURANCE OR SCHOOL NA	( )			
MM       DD       YY       MM       PACE (Base)         MM       DD       YY       MM       PACE (Base)       MM         MM       DD       YY       MM       DD       MM       M	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	
MM       DD       YY       MM       PACE (Base)         MM       DD       YY       MM       PACE (Base)       MM         MM       DD       YY       MM       DD       MM       M				
OTHER BURCEDS DATE OF BIRTH       B. AUTO ACCIDENT       PLACE (Stulp)       E. EMPLOYER'S NAME OF SCHOOL NAME         MILLOYER'S NAME OF SCHOOL NAME       C. OTHER ACCIDENT       C. OTHER ACCIDENT       C. INSURANCE PLAN NAME OF PROGRAM NAME         INSURANCE PLAN NAME OF PROGRAM NAME       Tos. RESERVED FOR LOCAL USE       I. IS THERE ANOTHER HEALTH SENETT PLAN?         INSURANCE PLAN NAME OF PROGRAM NAME       Tos. RESERVED FOR LOCAL USE       I. IS INSURED SCHOOL NAME         INSURANCE PLAN NAME OF PROGRAM NAME       Tos. RESERVED FOR LOCAL USE       I. IS INSURED SCHOOL NAME         INSURANCE PLAN NAME OF PROGRAM NAME       Tos. RESERVED FOR LOCAL USE       I. IS INSURED SCHOOL NAME         INSURANCE PLAN NAME OF RECORPECTION BEFORE COMPLETING A SIGNING THIS FORM.       I. IS INSURED SCHOOL NAME       I. IS INSURED SCHOOL NAME         INSURED SCHOOL NAME       Tos. DESCRIPTION INFORMATION INFOR	OTHER INSURED'S POLICY OR GROUP NUMBER		MM DD YY	-
MAX       DD       YY       MX       PLACE CEREMON       PLACE CEREMON       PLACE CEREMON       MAX         EMPLOYERS NAME CR SCHOOL NAME       - OTHER ACCOUNT       - OTH			i I 🖵	<u>-                                     </u>
EMPLOYERS INAME OR SCHOOL HARE       c. OTHER ACCIDENT       c. INSURANCE PLAN NAME       c. INSURANCE PLAN NAME OR PROGRAM NAME         INSURANCE PLAN NAME OR PROGRAM NAME       10d. INSURPCY OR LOCAL USE       d. IS THERE ANOTHER HEALTH BENEFIT PLAN?         INSURANCE PLAN NAME OR PROGRAM NAME       10d. INSURANCE PLAN NAME OR SCHOOL ALLYSE       d. IS THERE ANOTHER HEALTH BENEFIT PLAN?         INSURANCE PLAN NAME OR PROGRAM NAME       10d. INSURED'S ON ALTHORIZATION BENEFIT PLAN?       INSURED'S ON ALTHORIZATION BENEFIT PLAN?         INSURED'S OR ALTHORIZATION DATES       INSURED'S ON ALTHORIZATION INTO THE Institute is any within a draft information neosynthesis and segment information neosynthesis and segment information neosynthesis and segment information neosynthesis and segment of neosynthesis and segment information neosynthesis andifferences       INSUE SEGMENT IN	MM DD YY		D. EMPLOYER'S NAME OR SCHOOL NAME	
INSURANCE PLAN NAME OR PROGRAM NAME  IDD. RESERVED FOR LOCAL USE  IDD. RES			C. INSURANCE PLAN NAME OR PROGRAM NAME	
PATENTS ON AUTHORIZED PERSON'S SIMATURE is authorized as signing and call or other information necessary before the index of the second assignment being and the other information necessary before the index of the second assignment before the undergoed physician or applied for the physician of a specific bit calls. Is assigned physician of applied for the ph				
READ BACK OF FORE BEFORE COMPLETING & SIGNING THE FORM.         PATENTSY GR ALTER/DECED SERVICES         PATENTSY GR ALTER/DECED FERSON'S SIGNATURE I authors the index day moted of or the information necessary is be claim. I also request payment of government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government benefits either to myself or to the party who accepts assignment to government and to government benefits either to myself	INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
PATEINS OR AUTHORIZED PERSONS SIGNATURE L authorizes the release of any medical or other information necessary before a solution of the party who accepts assignment of advertises described below.			YES NO If yes, return to and complete ite	əm 9 a-d.
to proceed this claim. I also request payment of government benefits either to myself or bit the party who accepts assignment services described below.  SIGNED				
SIGNED     DATE     SIGNED       DATE OCURRENT     ILLNESS (First symptom) OR PREGNACCYLMP)     15. (F PATIENT HAS HAD SAME OR SIMLAR ILLNESS (IRLE PATIENT HAS HAD SAME OR SIMLAR ILLNESS (IRLE PATIENT HAS HAD SAME OR SIMLAR ILLNESS (IRLE PATIENT HAS HAD SAME OR SIMLAR ILLNESS IRLE DATES PATIENT (NAUBLE T) WORK IN CURRENT CCUPRENT COURSENT (IRLE PATIENT HAS HAD SAME OR SIMLAR ILLNESS IRLE DATES PATIENT (NAUBLE T) WORK IN CURRENT CCURRENT COURSENT (IRLE PATIENT HAS HAD SAME OR SIMLAR ILLNESS IRLE DATES PATIENT HAS HAD AND THE PATIENT HAS	to process this claim. I also request payment of government benefits e			supplier for
DATE OF CURRENT:       ILLNESS (First symptom) OR PREGNANCY(LMP)       16. IF PATIENT HAS NAD SAME OR SIMULAR ILLNESS (GW FIRST DATE: MM D D W)       16. IF PATIENT HAS NAD SAME OR SIMULAR ILLNESS       16. DATES PATIENT WABLE TO WORK IN CURRENT OCCUPATION PROM TO TO TO WORK IN CURRENT OCCUPATION PROM TO TO WORK IN CURRENT OCCUPATION PROM TO WORK IN CURRENT SERVICES, PROM TO WILLNESS CRI INJURY (Relate Items 1. 2. 3 or 4 to Item 24E by Line)       18. HORD RESUBNISSION ORIGINAL REF. NO.         DIATE (G) OF SERVICE M DO YY MM DO YY I ENNCE M DO YY MM DO YY EXPRCE M DO YY EXPRCE       C. PROM TO WILLNESS CRI INJURY (Relate Items 1. 2. 3 or 4 to Item 24E by Line)       20. OUTSIDE LAR?       0. OUTSIDE LAR?         A DATE(G) OF SERVICE M DO YY MM DO YY EXPRCE M DO YY MM DO YY EXPRCE M DO YY		DATE	SIGNED	
Image: Construct Structure       Transmit       Trans	DATE OF CURRENT: ILLNESS (First symptom) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.		PATION
17b.       NPI       FROM       j       TO       j         RESERVED FOR LOCAL USE       20. OUTSIDE LAB?       \$ CHARGES         DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1. 2. 3 or 4 to Item 24E by Line)		GIVE FIRST DATE MM I DD I YY	FROM TO	
17b. NPI       FROM       TO         17b. NPI       20. OUTSIDE LAB?       \$ CHARGES         DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)       3. L       22. MEDICAD RESUMMISSION         ORIGINAL REF. NO.       3. L       3. L       23. PRIOR AUTHORIZATION NUMBER         Image: Comparison of the comparison o	NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVI	ICES YY
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)      J		17b. NPI	FROM TO	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	. RESERVED FOR LOCAL USE			
	DIACNOSIS OF NATURE OF ILLNESS OF IN ILIPY (Palata Itana	1. 2. 2 or 4 to Itom 24E by Lipp)		
A DATE(S) OF SERVICE     B     C     D     PROCEDURES, SERVICES, OR SUPPLIES     DIAGNOSIS     From     D     YV     MM     D     YV     SERVICE     EMG     C		<b>↓</b>	CODE ORIGINAL REF. NO.	
A. DATE(s) OF SERVICE       B. C. D. PROCEDURES, SERVICES OR SUPPLIES From TO TO UNUSUAL Circumstances)       E. DIAGNOSIS       F. O. DATE(S) OF SERVICE INFO CONCENTRATION       H. I. D. M. PROTEING DAY MIN DD YY       I. D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)       E. DIAGNOSIS       S CHARGES       H. I. D. PROVIDERING DAY BAD OUT       H. I. D. PROVIDERING OUT       H. I. D. PROVIDERING OUT       H. I. D. PROVIDERING OUT       I. I. D. PROVIDERING OUT       I. I	· ·	3.	23. PRIOR AUTHORIZATION NUMBER	
A. DATE(s) OF SERVICE       B. C. D. PROCEDURES, SERVICES OR SUPPLIES From TO TO UNUSUAL Circumstances)       E. DIAGNOSIS       F. O. DATE(S) OF SERVICE INFO CONCENTRATION       H. I. D. M. PROTEING DAY MIN DD YY       I. D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)       E. DIAGNOSIS       S CHARGES       H. I. D. PROVIDERING DAY BAD OUT       H. I. D. PROVIDERING OUT       H. I. D. PROVIDERING OUT       H. I. D. PROVIDERING OUT       I. I. D. PROVIDERING OUT       I. I				
M DD YY MM DD YY SERVICE EMG CP1/HCPCS MODIFIER POINTER \$ CHARGES UNITS Per QUAL PROVIDER ID. # PHOVIDER ID. #	I. A. DATE(S) OF SERVICE B. C. D. PR	DCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.	
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (or group claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         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.)       28. SERVICE FACILITY LOCATION INFORMATION       28. BILLING PROVIDER INFO & PH # ( )			S CHARGES     UNITS     Plan     UL     PROVIDI     S CHARGES	
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (or group dame, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (or group dame, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Locitify 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 # ( )       )				
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For gov. claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         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.)       28. SERVICE FACILITY LOCATION INFORMATION       28. DELLING PROVIDER INFO & PH # ( )			NPI	
. FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For govt. claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         . 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.)       28. SERVICE FACILITY LOCATION INFORMATION       33. BILLING PROVIDER INFO & PH # ( )				
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For good, claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Icertify 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 # ( )			NPI	
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For good, claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Icertify 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 # ( )				
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (por gove, claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (clorify 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 # ( )				
. FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For govi. claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         . 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 # ( )         a.       b.       a.       b.			NPI	
i. FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For govi. claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         . 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 # ( )         a.       b.       a.       b.				
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For govt. claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         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 #       ( )         a.       b.       a.       b.			NPI	
FEDERAL TAX I.D. NUMBER       SSN EIN       26. PATIENT'S ACCOUNT NO.       27. ACCEPT ASSIGNMENT? (For govt. claims, see back)       28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DUE         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 #       ( )         a.       b.       a.       b.				
. 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 # ( )         a.       b.       a.       b.				
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 # ( )         a.       b.       a.       b.	- FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIEN			
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	I. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVIC			
apply to this bill and are made a part thereof.)           a.         b.         a.         b.	INCLUDING DEGREES OR CREDENTIALS	-		
GNED DATE a. b. a. Do b.				
GNED DATE a. NPI b. a. NPI b.				
	IGNED DATE a.	NPI b.	a. NPI b.	

NUCC Instruction Manual available at: www.nucc.org

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

HEA	ALTH INS	URAI	NCE	E CL	AIN	ЛFC	RM		++	+++	+++	++	$\left  \right $		+++	+	H	++	+	+	+	+	+		+	++	++	++	+	++	++	
																											Ħ	Ħ	$\pm$	$\pm$	$\pm$	(
	PICA																												PI			
				- CHAI	ARE			AMP\			OUP	AN	FEC	CA LUNG W)			1a.	INSU	RED	'S I.D	. NUN	1BER				(Fo	or Pro	ogram	in Ite	əm 1)	$\square$	
		(Medicaid		(Spor	nsor's S	SSN)	(Me	ember l		(SS	N or ID)		-		(11		$\parallel$				· a .		+				++	- n	$\downarrow\downarrow$	++	+	╡
2. PA I	FIENT'S NAME (I	ast Name	ı, First r	Name, I	Middle	Initial)	H		3. P	ATIENI	"S BIRT	H DA I YY	E	SI I	EX	╫╫	4. Ir	NSUH	ED	5 NAN	ΛΕ (La	ast Na	ıme, ı	First	Vame,	Middl	le Initi	ial)	++	++	++	+
5. PAT	TIENT'S ADDRES	SS (No., S	treet)	++	+++	++-'	H	$\left  \right $	6. P	ATIEN	RELAT	IONSH	<sup>™</sup> L		F	┦╎╽	7. 1	N\$UR	ED'S		RES	S (No.	Stre	et)	+	+	++	++	+	++	++	+
				++	+++	++	H	$\left  \right $		Self	Spous		Child		Other	++	Ĥ					-	, -		+	++	++	++	++	++	++	+
CITY	+++++	+++	+++	++	+++	++	s	ΤΑΤΕ			STATU		T I			╇╫	СІТ	Y	+		+	+	+	+	+	+	++	+	STA	TE	++	+
++	++++++	++++	+++	++	$\left  \right $					Single		Marrie	ed	1	Other	+	Ĥ	++	+		+	+	+	+	+	++	++	$+ \parallel$	計	++	++	0.1
ZIP CC	JDE		TELE	PHON	E (Incl	ude Are	a Code)									┦╽	ZIP	COD	E			+		FELE	PHON	IE (Inc	clude /	Area (	Code	)	+	
			(	)					Er	nployed		-ull-Tin Studeni		Part Stud	-Time lent									(		)						
9. OTH	HER INSURED'S	NAME (La	ast Nan	ne, Firs	st Nam	e, Midd	e Initial)		10.1	S PATI	ENT'S C	юлріт	FION F	RELATE	D TO		11.	INSU	RED	'S PC	ILICY	GRO	UP O	R FE	CA N	имве	:R	Ŧ	Ī	$\square$		
Щ.		$\downarrow\downarrow\downarrow\downarrow\downarrow$	$\parallel \mid \mid$	Ш			Ц																				Щ	$\square$	Щ			6
a. OTH	HER INSURED'S			OUP N	UMBE	R	$\square$		a. E	MPLOY	MENT?		nt or F		s)		a. II	NSUR	ED'S MM	S DAT	E OF	BIRT	Ή (				S	SEX	ļ		—	
				++	₩		H					ES T2		NO		++	H								M		#	#	<u></u>	╨	$\blacksquare$	_ <b> </b>
MM	HER INSURED'S				I SI	EX F	┝╋┼╴	$\left  \right $	0. ~			E\$	┤┢┥		ACE (S	tate)	b. ⊨	MPLO	JYE	R'S N	AME	ORS	СНО	OL N	AME	++	++	++	+	++	++	
∩ EMF	PLOYER'S NAMI	F OR SCH		M	╇┿	┿┸	┝╇┝	$\left  \right $		THER			┦┡┥		+++	╵┼┼╊	c. I	USUR	ANC	FPL		ME C	אר R Pl	RNG			++	++	++	++	+	
0. 2.011					+++	++-			0.0		-	E\$		NO			0. 1							100	U CIVI I	v, uvic		++	++	++		
d. INSI	URANCE PLAN	NAME OR	PROG		JAME	++			10d.	RESE	RVED F		CAL U	ISE			d. 19	S THE	RE	ANOT	HER	HEAL	.тн е	BENE	FIT PI	_AN?	+++	++	++	+	-	-
																	Ħ	$\square$	YES	;	N	0	lf y	/es, r	eturn	to and	i com	plete i	item <sup>,</sup>	9 a-d.		ť
10 04		READ	BACK	OF FC		EFORE	COMPL	ETIN	G & \$I	GNING	THIS F	ORM.	ar info	motion			13.	INSU	RED	'S OR	AUT	HORI	ZED	PER	SON'S	SIGN	νΑΤΨ	REIa	autho	rize		1
to p	TIENT'S OR AU process this claim	n. I also req	juest pa	ayment	of gove	ernment	benefits	ze trie either	releas to mys	e or an self or to	the par	ty who	accept	ts assig	necess	ary		paym servic					s to ti	he un	dersig	jned p	hysici	cian or	supp	olier fo	or	
belo	ow.	$\downarrow$					Ш																									
	GNED			#														-	NED	-		++					#	<u></u> <u> </u>	∔	++	#	
14. DA MM	ATE OF CURREN	YY 📢 I	INJURY	Y (Accio	dent) 🛈	otom) OF	R	15.	IF PA GIVE	TIENT I FIRST	HAS HA DATE	D SAM	E OR DD	SIMILA	r illn	ESS.	++		M		IT UN DD	ABLE	TO N	WOR		MN			JPAT	ION		4
		F	PREGN	NANCY	(LMP)			17										FROM					2 RFI		тс от о				VICE		++	+
17.107						500110		17a 17a	_+	+			T 1		1-1-1			FROM		M	DD		YY		тс		4	「SER' DD		Ϋ́Υ	++	+
19. RE	ESERVED FOR L		E	++	+++	++-	┝╋╋	1	0		+++		++		+++	++		OUTS		LAB	,	il	+			HARC	i GES	┿	++	++	++	╉
			+++	++	+++	++	$\mathbb{H}$	$\left  \right $	+	+++		++	$\left  \right $		$\left  \right $	++	F		YE			10	+	+	+		+	++	+	++	++	+
21. DI/	AGNOSIS OR N/	ATURE OF	FILLNE	ESS OF		RY (Rel	ate Iterr	is 1, 2	, 3 or 4	to Item	24E by	Line)	+	Ħ	$\ddagger$		22	MEDI					N					++	+	+	++	+
1	+++++	+++	+++	+			$\square$	3		+++		++					Ħ	CODi			+		- Ψ	RIGi		REF. N	10.	++	+	++	++	+
		$\uparrow \downarrow \downarrow \downarrow$			$\square$			Ĭ		11.					$\square$		23.	PRIO	RA	лтно	RIZA	FION I	NUM	BER			++	++	+	+	+	1
2.								4																			Ш	Ш				
24. A.	DATE(S) O		Ж To		B. PLACE O	C.	D. P	ROCE	EDURE		RVICES, ircumsta			ES	E. DIAGN				F.			G. DAYS	E FF	H. PSDT	<u> </u> .			REND	J. DEBI			
мм	DD YY			YY	SERVICE		CP	(Expi T/HCF		usuai C	M	DDIFIE	R		POIN			\$ CH	ARC	εs			S Fa	amily I	ID. QUAL			ROVI				l
										1										-1-1									т п	-1-1-		
																									NPI		ш	ш	ш	Ш		ļ
11										1 1 1	111	111	1 11							1.1				. h	J.J.				тп	-1-6		
																									NPI							-
	a cucio									111					111	111		11			-111	11	111	цh	NPI		ירר		TT	-1-1		
<u> </u>			i										<u>   i</u>				-				- 111		111		INFI							
	a na na	a i din	TH							111					111			11				11		тþ	NPI	ТТ	111		Т٦			- 6
																	_											_				
																								Π	NPI	161	777		11	111		
																									NPI				11			1
25. FE	EDERAL TAX I.D.	. NUMBER	1	SSN	EIN	26	. PATIE	NT'S	ACCO	UNT NO	).	27. A	CCEP or govt.	T ASSI claims, s		IT?	28.	ΤΟΤΑ	IL C	HARC	iΕ	2	29. AI	мои	NT PA	١D		0. BAL	LANC	)Е DU	JE	
					Ш								YES		NO		\$						\$				\$					
	GNATURE OF PI					32	. SERVI	ICE F/	ACILIT	Y LOC	ATION II	NFORM	ΛΑΤΙΟ	N			33.	BILLI	NG F	PROV	IDER	INFO	& P	+#	(	)	1	$\square$	$\square$			
	certify that the sta ply to this bill and	atements o	on the re	everse			$\square$																+						++	$\square$		$\downarrow$
INC (I c	Jiy to this bin and	are made	, a pan		··./		$\vdash$			+++					+++		$\square$												++	++		_
INC (I c		++++	+++	++	+++		H											++														+
INC (I c				DATE	$\parallel$	a.	╘┼┼╴	N	H		b.	-				_	a.	+		1L			b.			-			_	_	_	
INC (I c app SIGNE			_		at: wv	vw.nu	cc.org			+++			$\left  \right $		+++	++	H	AF	PP	NON	ΞÞ ¢	2MB	-093	38-0	999	FOR	ĭΜ C	SW2-	-150	)0 (0	08/05	5)
INC (I c app SIGNE	≡⊅ C Instruction	Manual	availa	able a			5 I I I								1 1 1		1.1	1.1	11	11	11	11	11	1.1	- 1 - F	1.1	1.1	- 1 - i -			11	1
INC (I c app SIGNE		Manual	availa	able (			Щ						$\left  \right $		+++			++					++				++	++	++	++	++	+
INC (I c app SIGNE		Manual	avail														H										#	+	+	+	$\mp$	+
INC (I c app SIGNE		Manual	avail																									++ ++	++ ++ ++			

## **HEALTH INSURANCE CLAIM FORM**

		$\uparrow$
	1500	CARRIER
	IEALTH INSURANCE CLAIM FORM	ARF
	PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	ī
		XX
	I. MEDICARE MEDICAID TRICARE CHAMPUS (For Program in Item 1) CHAMPUS (Medicare #) X (Medicaid #) X (Sponso's SSN) X (Member ID#) X (SSN or ID) X (SSN) (ID) X (ID) X XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	x  ↑
	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial) MM   DD   YY	
	<pre>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</pre>	X
	5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)	
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	AND INSURED INFORMATION
	ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code)	- AM
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	X R
	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	IN I
	A. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX	. <u>×</u> 닕
		ISU
	D. OTHER INSURED'S DATE OF BIRTH SEX     D. AUTO ACCIDENT?     PLACE (State)     D. EMPLOYER'S NAME OR SCHOOL NAME	≦
	C. EMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT? C. INSURANCE PLAN NAME OR PROGRAM NAME	PATIENT
	VXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	X
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
	READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize	-
	2. 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 SIGNED SIGNED SIGNED SIGNED DATE OF CURRENT:  # ILLNESS (First symptom) OR 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	<b>-</b>  -
	MM DD YY INJURY (Accident) OR GIVE FIRST DATE MM DD YY A DD YY A DD YY	
	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	.
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	·
		$\mathbf{x}$
	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
	1. LXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXX	X
	23. PRIOR AUTHORIZATION NUMBER	
	2.         XXXXXXX         4.         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
	From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS DAYS EPSOT ID. RENDERING MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER \$CHARGES UNTS Par QUAL PROVIDER ID. #	
1	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	X X X INFORMATIO
	KX XX X	<mark>Х</mark> р
2		
_	<pre>XX : XX : XX : XX : XX : XX : XX : XX</pre>	SUPPLIER
3	(X   XX   XX   XX   XX   XX   XX   XX	्रि दि
4	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	
т	XX	XQ
5	<pre>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</pre>	
	XX   XX   XX   XX   XX   XX   XX   XX	PHYSICIAN OR
6	(X XX X	X
	25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE	
		<u>X</u>
	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (1) codified the activation of the two provided in the structure of the struct	.X   - V
	(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	$\hat{\mathbf{x}}$
		X
	SIGNED DATE a. XXXXXXXXXX b. XXXXXXXXXXXXXXXXXXXXXX	X ↓

NUCC Instruction Manual available at: www.nucc.org

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

#### BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

#### REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

### BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

# NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT) We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung

programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

<u>ROUTINE USE(S)</u>: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches. MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

# WARNING

Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

**Arizona Residents:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.