

Revised CMS-1500 Health Insurance Claim Form (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (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	4. INSURED'S NAME
5. F. RELATIONSHIP TO INSURED M <input type="checkbox"/> F <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS	8. INSURED'S CITY
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. OTHER EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	11. INSURED'S POLICY GROUP OR LEAF NUMBER
12. REFERRING PHYSICIAN'S SIGNATURE I authorize the release of any medical or other information necessary for payment of government benefits either to myself or to the party who accepts assignment		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical services described	14. DATES PATIENT IN HOSPITALIZATION FROM MM DD TO MM DD
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT IN OUTSIDE LAB? FROM MM DD TO MM DD	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. NAME OF REFERRING PROVIDER OR OTHER SOURCE	20. NAME OF REFERRING PROVIDER OR OTHER SOURCE
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate item to procedure)		22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate item to procedure)	23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate item to procedure)
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. EPSPOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		25. PATIENT'S ACCOUNT NO.	26. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>
27. SERVICE FACILITY LOCATION INFORMATION		28. TOTAL CHARGES \$	29. BILLING PROVIDER INFO & PH # ()

Box 1

- "TRICARE" added above "CHAMPUS".
- Under CHAMPVA, "VA File #" changed to "Member ID#".

Back

- The following language is added in the last line at the bottom: "This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS."

HEADER

- Barcode removed.
- "PLEASE DO NOT STAPLE IN THIS AREA" removed from left side.
- Rectangle with "1500" added to left side.
- "HEALTH INSURANCE CLAIM FORM" moved to left side.
- "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05" added to left side.

Upper/Lower Case Format Changes:

- Box 1a: "FOR PROGRAM IN ITEM 1" changed to "For Program in Item 1"
- Box 7: "INCLUDE AREA CODE" changed to "Include Area Code"
- Box 10: "CURRENT OR PREVIOUS" changed to "Current or Previous"
- Box 21: "RELATE ITEMS 1,2,3 OR 4 to ITEM 24E BY LINE" changed to "Relate Items 1,2,3 or 4 to Item 24E by Line".
- Box 24B: "Place of Service" changed to "PLACE OF SERVICE"

Box 17a

- Box is split in half length-wise.
- Area is shaded. Box will accommodate other ID numbers.
- Two vertical lines added. Field will accommodate a two byte qualifier for other ID numbers.

Box 24K

- This field, "RESERVED FOR LOCAL USE", was removed.

Field size changes

- Box 24D: Increased by three bytes.
- Box 24E: Decreased by three bytes.
- Box 24G: Increased by one byte.
- Box 24H: Decreased by one byte.

Box 17b

- Field is added.
- Two vertical lines added with "NPI" label.
- Field will accommodate the NPI number.

Box 17

- "NAME OF REFERRING PHYSICIAN..." changed to "NAME OF REFERRING PROVIDER..."

Box 24J

- Title is changed from "COB" to "RENDERING PROVIDER ID. #".
- A dotted horizontal line is added length-wise separating the shaded and unshaded portions. The NPI number is to be reported in the unshaded field. Another ID number can be reported in the shaded field.

Box 21

- Lines after decimal point in items 1, 2, 3, and 4 are extended to accommodate four bytes.

Box 24C

- "Type of Service" is removed. Field is now titled "EMG".

Box 32

- Boxes 32a and 32b were added at the bottom.
- Box 32a: This field is added to accommodate reporting of the NPI number and is indicated by the shaded label of "NPI".
- Box 32b: This shaded field is added to accommodate the reporting of other ID numbers.

Box 24I

- Title changed from "EMG" to "ID. QUAL.".
- Horizontal line added separating the shaded and unshaded portions.
- "NPI" was added in the unshaded portion.

Box 24

- Line with alpha indicators is removed. Alpha indicators are moved next to respective titles.
- Line numbers to the left of Box 24 are increased in size.
- Each of the six lines are split length-wise and shading is added. This area is for the reporting of supplemental information.
- Vertical line separators on each of the six lines are removed from the shaded area, except for the lines before Boxes 24I and 24J

Box 24D

- Shading is added vertically between "CPT/HCPCS" and "MODIFIER".
- Vertical lines are added in unshaded "MODIFIER" section to accommodate four sets of two bytes.

Box 24E

- Title is changed from "DIAGNOSIS CODE" to "DIAGNOSIS POINTER".

Box 33

- "PHYSICIAN'S, SUPPLIER'S, BILLING NAME, ADDRESS, ZIP CODE, & PHONE #" changed to "BILLING PROVIDER INFO & PH #".
- Parentheses are added to indicate the location for reporting the telephone number.
- Boxes 33a and 33b are added at the bottom.
- Box 33a: Title changed from "PIN#" to "a". Shaded label of NPI is added to indicate the reporting of the NPI number.
- Box 33b: Title changed from "GRP#" to "b." to accommodate reporting of other ID numbers. Field is shaded.

Footer

- The language "NUCC Instruction Manual available at: www.nucc.org" was added to the left-hand side.
- "Please Print or Type" was removed from the center.
- Approved by AMA Council on Medical Service 8/88" was removed from the left-hand side.

Footer

- "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" added to lower, right-hand corner.

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Changes in blue • Source of changes: www.nucc.org/images/stories/PDF/final_1500_change_log.pdf

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (ID)</small>		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)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
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:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <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) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		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"/>		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		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
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.		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.	
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 _____ DATE _____	
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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 of Item 24E by Line)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID 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		23. PRIOR AUTHORIZATION NUMBER _____	
F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN <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	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # ()	
a. NPI _____ b. _____		a. NPI _____ b. _____	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION