

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

Changes in blue • Source of changes: [www.nucc.org/images/stories/PDF/final\\_1500\\_change\\_log.pdf](http://www.nucc.org/images/stories/PDF/final_1500_change_log.pdf)

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

HEALTH ADVANTAGE, INC  
PO BOX 1511  
FLINT, MI 48501-1511

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 checked="" 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) <b>555-55-0055</b>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Smith, Ann G</b>				3. PATIENT'S BIRTH DATE MM DD YY SEX <b>06 15 55</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) <b>1234 Anywhere Ave</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY <b>Okemos</b>		STATE <b>MI</b>		CITY <b>Okemos</b>		STATE <b>MI</b>	
ZIP CODE <b>48864</b>		TELEPHONE (Include Area Code) <b>(517) 555-5555</b>		ZIP CODE <b>48864</b>		TELEPHONE (Include Area Code) <b>( ) ( )</b>	
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) <input type="checkbox"/> YES <input type="checkbox"/> NO			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			
11. INSURED'S POLICY GROUP OR FECA NUMBER <b>BCCCP</b>				a. INSURED'S DATE OF BIRTH MM DD YY SEX <b>06 15 55</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
b. EMPLOYER'S NAME OR SCHOOL NAME				b. INSURANCE PLAN NAME OR PROGRAM NAME			
c. INSURANCE PLAN NAME OR PROGRAM NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			
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 <b>SIGNATURE ON FILE</b> 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 <b>SIGNATURE ON FILE</b>			
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI <b>1346269644</b>		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
19. RESERVED FOR LOCAL USE							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 of Item 24E by Line) 1. <b>V72.31</b>				23. PRIOR AUTHORIZATION NUMBER			
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. EPSDT Family Plan	
I. ID. QUAL		J. RENDERING PROVIDER ID. #					
1 <b>03 06 07</b>		11		99213		77 00 1	
2		11		99213		NPI	
3		11		99213		NPI	
4		11		99213		NPI	
5		11		99213		NPI	
6		11		99213		NPI	
25. FEDERAL TAX I.D. NUMBER <b>382853534</b>		26. PATIENT'S ACCOUNT NO. <b>1234500</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>77.00</b>	
29. AMOUNT PAID \$ <b>00</b>		30. BALANCE DUE \$ <b>77.00</b>					
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.) <b>RICHARD, ROBERT</b> 08/27/2007				32. SERVICE FACILITY LOCATION INFORMATION <b>WESTSIDE HEALTH CENTER</b> <b>669 STOCKING NW</b> <b>GRAND RAPIDS, MI 49504</b> a. 1891867495 b.			
SIGNED DATE				33. BILLING PROVIDER INFO & PH # <b>CHERRY STREET HEALTH SVC</b> <b>101 SHLDON BLVD, STE 1</b> <b>GRAND RAPIDS, MI 49503</b> a. 1558459164 b. 382853534			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION