PLEASE DO NOT STAPLE IN THIS AREA

EXAMPLE CMS-1500 CLAIM FORM

PICA — Payor Code

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (X) (Medicare #) — MEDICAID (Medicaid #) — CHAMPUS (Sponsor's SSN) — CHAMPVA (VA File #) — GROUP HEALTH PLAN (SSN or ID) — FECA BLK LUNG (SSN) — OTHER (ID)

1a. INSURED'S I.D. NUMBER: 000-00-0000 → Recipient Number

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN → Recipient Name

3. PATIENT'S BIRTH DATE: MM DD YY → Recipient Birth Date — SEX M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self — Spouse — Child — Other

7. INSURED'S ADDRESS (No., Street)

CITY — Required when Applicable

STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

Required when Applicable - Enter an 'X' in all applicable blocks

Employed — Full-Time Student — Part-Time Student

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( ) — Required when Applicable

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO — 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 ... ment of govern...

Required when Applicable - Enter Physician's Name

Required when Applicable - Enter Physician's ND Medicaid Provider Number or UPIN Number

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for servicos described below.

SIGNED

14. DATE OF CURRENT: ... (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 PHYSICIAN OR OTHER SOURCE: JOHN SMITH, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 99999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

Required when Applicable - Prior Authorization Number

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 9 99 → Enter ICD-9-CM Medical Diagnosis Code
2.
3.
4.

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION: 99999

If Billing Provider in Block 33 is a *Group* Practice, you must enter Physician's ND Medicaid Provider Number or UPIN

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 04	01 01 04	11		89999	26	1,2,3,4	10 00	01	Y			99998
2												
3												
4												
5												
6												

FROM Date of Service MMDDYY Format

TO Date of Service MMDDYY Format

Use Appropriate Place of Service Code

Enter the Appropriate CPT/HCPCS code, including any applicable modifiers

Enter the Appropriate Diagnosis Code Pointer

Enter the Procedure Detail Charge

Enter the Procedure Number of Units

Enter a 'Y' if result of Health Tracks referral

Total Charges for Claim

Other Insurance

Balance Due

Federal Tax ID Number

Signature of Provider

Patient Account #

If services provided somewhere other than address in Block 33, enter address here

25. FEDERAL TAX I.D. NUMBER: 99-9999999 — SSN EIN

26. PATIENT'S ACCOUNT NO.: ABCDEFG

27. ACCEPT ASSIGNMENT? For govt. claims, see back

28. TOTAL CHARGE $ 10 00

29. AMOUNT PAID $ 00 00

30. BALANCE DUE $ 10 00

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.)

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

PROVIDER NAME
ADDRESS
CITY, STATE, ZIP CODE

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PROVIDER NAME (BILLING)
ADDRESS (BILLING)
CITY, STATE, ZIP CODE

PIN# 99997 → ND Medicaid Provider # — GRP #

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)