

PLEASE DO NOT STAPLE IN THIS AREA

# EXAMPLE CMS-1500 CLAIM FORM

CARRIER

PICA	Payor Code	HEALTH INSURANCE CLAIM FORM										PICA									
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	INSURED'S I.D. NUMBER					Recipient Number									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							3. PATIENT'S BIRTH DATE (MM DD YY)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)												
DOE, JOHN							MM DD YY														
5. PATIENT'S ADDRESS (No., Street)							6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)												
CITY							Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		CITY												
Required when Applicable							Required when Applicable - Enter an 'X' in all applicable blocks		Required when Applicable												
ZIP CODE							Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP 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)		a. INSURED'S DATE OF BIRTH												
b. OTHER INSURED'S DATE OF BIRTH							b. AUTO ACCIDENT? PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME												
c. EMPLOYER'S NAME OR SCHOOL NAME							c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME												
d. INSURANCE PLAN NAME OR PROGRAM NAME							10c. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE							13. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE												
Required when Applicable - Enter Physician's Name							9999		Required when Applicable - Enter Physician's ND Medicaid Provider Number or UPIN Number												
14. DATE OF ONSET OF FIRST SYMPTOM OR INJURY (Accident) OR PREGNANCY (LMP)							15. DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION												
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE							17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
JOHN SMITH, MD							99999		FROM TO												
19. RESERVED FOR LOCAL USE							20. RESERVED FOR LOCAL USE		20. RESERVED FOR LOCAL USE												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE TO ICD-9-CM 2,3 OR 4 TO ITEM 24E BY LINE)							22. MEDICAR RESUBMISSION CODE		23. PRIOR AUTHORIZATION												
999							99999		99999												
24. A. DATE(S) OF SERVICE							B. Place of Service		C. Type of Service		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS CODE		F. CHARGES		G. DAY OF UNITS		H. LOCAL USE		
01 01 04		01 01 04		11		89999		26		1,2,3,4		10 00		01		Y		99998			
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	
99-9999999		Signature of Provider		Patient Account #		if services provided somewhere other than address in Block 33, enter address here		10 00		00 00		10 00		PROVIDER NAME (BILLING)		ADDRESS (BILLING)		CITY, STATE, ZIP CODE		ND Medicaid Provider #	
25. FEDERAL TAX I.D. NUMBER							26. PATIENT ACCOUNT NO.		27. TOTAL CHARGE				28. AMOUNT PAID		29. BALANCE DUE						
99-9999999							ABCDEFGH		10 00				00 00		10 00						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS							32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #												
PROVIDER NAME ADDRESS CITY, STATE, ZIP CODE							PROVIDER NAME ADDRESS CITY, STATE, ZIP CODE		PROVIDER NAME (BILLING) ADDRESS (BILLING) CITY, STATE, ZIP CODE												

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION