1500

HEALTH INSURANCE CLAIM FORM

CMS 1500 (08/05)

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ABC1234567800 ← Member I.D. Number (No Suffix for CompSelect®/ Comprehensive Major Medical [CMM])

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John B.

3. PATIENT'S BIRTH DATE MM 03 DD 20 YY 71 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle): Doe, John B.

5. PATIENT'S ADDRESS (No., Street): 1234 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 1234 Main Street

CITY: Philadelphia STATE: PA

8. PATIENT STATUS: Single Married [X] Other; Employed Full-Time Student Part-Time Student

CITY: Philadelphia STATE: PA

ZIP CODE: 19111 TELEPHONE (Include Area Code): (610) 555-5555

ZIP CODE: 19111 TELEPHONE (Include Area Code): (610) 555-5555

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 15974

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 72431

a. EMPLOYMENT? (Current or Previous): YES NO [X]

a. INSURED'S DATE OF BIRTH MM 03 DD 20 YY 71 SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM 10 DD 21 YY 70 SEX M F [X]

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Watch Repair, Inc.

c. EMPLOYER'S NAME OR SCHOOL NAME: self-employed

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Personal Choice

d. INSURANCE PLAN NAME OR PROGRAM NAME: HMO, Inc.

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] 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 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

14. DATE OF CURRENT: MM 10 DD 28 YY 06 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Josephine Smith, M.D.

17a. 1B 0123456789 ← Referring Provider's two-character qualifier ID; Referring Provider's Current Provider ID

17b. NPI 999999999 ← Referring Provider's NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM 11 DD 01 YY 06 TO MM 11 DD 04 YY 06

19. RESERVED FOR LOCAL USE: ZZ207LP2900X ← ZZ qualifier ID and Billing Provider's Primary Taxonomy Code

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 401 2. 251 8 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 123456789 ← Referral/Preauthorization 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	11 02 06	11 02 06	21	6	99205		1	$50 00	1		1B NPI	1234567000 8888888888
2	11 03 06	11 03 06	21	6	20600	25	2	$250 00	1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

← Two-character qualifier ID of the Rendering Provider; Modifier (if applicable)

25. FEDERAL TAX I.D. NUMBER: 22-1234567 ← Provider's Federal Tax ID # (Billing Entity) SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ $100 00

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.)

Richard B. Smith, M.D.

SIGNED DATE 11/5/06

32. SERVICE FACILITY LOCATION INFO: ABC Hospital, 123 Street, Anytown, PA 19003

a. 0000001234 b. 1B1234567002 ← Service Facility NPI; Service Facility two-character qualifier and Current Provider ID number

33. BILLING PROVIDER INFO & PH #: (215) 555-5555

ABC Medical Group, 8 North American Street, Anytown, PA 19003

a. 2222222222 b. 1B1234567001 ← Billing Provider NPI; Billing Provider two-character qualifier ID and current provider identification number

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING

Green items are required by Independence Blue Cross and its affiliates for payment.
Blue items are required for payment when applicable to the patient's condition/situation.
Black items are optional.

Indicates new field and/or requirement.

Indicates field required for processing.