

CMS-1500 Claim Form – Physician Office / Ambulatory Surgical Center

Box 21: Enter the appropriate ICD-9-CM diagnosis code

Box 24D: Enter the appropriate HCPCS and CPT codes. Example:

J2469 [Injection, palonosetronHCl, 25 mcg]

96375 [Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug]

Other administration codes may be appropriate

Box 24G: Enter the appropriate number of units (e.g., 10 for a 0.25 mg dose of ALOXI®)

Box 24I-J: National Provider Identifier

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Spouse's SSN) CHAMPVA (Member ID) GEBCO? HEALTH PLAN (SSN or ID) FECA BLK (LUNG) (SSN) OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM/DO/YY) SEX (M/F)

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)

8. PATIENT STATUS (Single/Married/Other)

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

10. IS PATIENT'S CONDITION RELATED TO: (Employment/Auto Accident/Other Accident)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES

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

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (From/To) B. PLACE OF SERVICE (EMG) C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DATE OR CHARGE H. UNIT (Perk/Rel) I. ID QUANT J. RENDERING PROVIDER ID #

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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24G

24D

24I-J