CMS-1500 Instructions

The following table identifies the fields that are required and provides a description of the field.

REQUIRED FORM FIELDs	DESCRIPTION
Element 01a – Insured's I.D. Number	Enter the identification number found on the insurer's card.
Element 02 – Patient's Name	Enter the recipient's last name, first name, and middle initial.
Element 03 – Patient's Birth Date, Patient's Sex	Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.
Element 04 – Insured's Name	Enter the insurer's Last Name, First Name, Middle Initial, generation (i.e. Sr., Jr.) if applicable, as listed on the members ID Card
Element05 – Patient's Address	Enter the patient's permanent mailing address
Element 06 - Patient Relationship to Insured	If applicable
Element 08 - Patient Status	If applicable
Element 09 - Other Insured's Name	If applicable
Element 10 - Is Patient's Condition Related to	If applicable
Element 11 – Insured's Policy, Group, or FECA Number	If applicable
Element 11a – Insured's Date of Birth and Sex	If applicable
Element 11b - Employer's Name or School Name	If applicable
Element 11c - Insurance Plan Name or Program Name	If applicable
Elements 12 and 13 - Authorized Person's Signature	If applicable
Element 14 - Date of Current Illness, Injury, or Pregnancy	If applicable
Element 15 - If Patient Has Had Same or Similar Illness	If applicable
Element 16 - Dates Patient Unable to Work in Current Occupation (not required)	If applicable
Elements 17 and 17a - Name and I.D. Number of Referring Physician or Other Source	If applicable
Element 18 - Hospitalization Dates Related to Current Services	If applicable
Element 20 - Outside Lab	If applicable
Element 21 - Diagnosis or Nature of Illness or Injury	Enter the most current International Classification of Diseases, Clinical Modification (ICD 10CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first.
Element 22 - Resubmission	If applicable, enter resubmission code and original claim number

Element 23 - Prior Authorization Number	If applicable
Element 24A - Date(s) of Service	Enter the month, day, and year for each service
Element 24A - Date(s) of Service	When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field. When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing only the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field. It is allowable to enter up to four DOS per line if: All DOS are in the same calendar month. All services are billed using the same procedure code and modifier(s), if applicable. All services have the same place of service (POS) code. All services were performed by the same provider. The same diagnosis is applicable for each service. The charge for all services is identical. (Enter the total charge per detail line in Element 24F.) The number of services performed on each DOS is identical. All services have the same family planning indicator, if applicable. All services have the same emergency indicator, if applicable.
Element 24B - Place of Service	Enter the appropriate two-digit POS code for each service.
Element 24C - Type of Service	If applicable
Element 24D - Procedures, Services, or Supplies	Enter the single most appropriate five-character procedure code. Claims received without an appropriate procedure code may be denied. Modifiers: Enter the appropriate modifier(s) in the "Modifier" column of Element 24D.
Element 24E - Diagnosis Code	Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-10CM diagnosis code listed in Element 21.
Element 24F - $ Charges	Enter the total charge for each line item.
Element 24G - Days or Units	Enter the appropriate number of days or units billed for each line item.
Element 24I – ID Qualifier	If applicable
Element 24J – Rendering Provider ID	837P- If rendering and billing NPI are the same follow EDI filing guidelines.
Element 25 - Federal Tax I.D. Number	Enter Tax ID
Element 27 - Accept Assignment	Enter “Yes” if the provider should be paid or enter “No” if the patient should be paid.
Element 28 - Total Charge	Enter the total charges for the claim.
Element 29 - Amount Paid	If applicable
Element 30 - Balance Due	Enter the balance due after any paid amount
Element 31 - Signature of Physician or Supplier	The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format. Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.
Element 32 - Name and Address of Facility Where Services Were Rendered	Enter the location where services were rendered if different than box 33.
Element 33 – Physician’s, Supplier’s Billing Name, Address, ZIP Code, and Phone #	Enter the provider’s name (exactly as indicated on the provider’s notification of certification letter) and address of the billing provider.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD 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)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area 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) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a and 9d.

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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										NPI
2										NPI
3										NPI
4										NPI
5										NPI
6										NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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