

CMS1500 Billing Tips

INSTRUCTION ADVICE FOR COMPLETING THE CMS1500 FORM FOR OREGON WORKERS' COMPENSATION CLAIMS

Field 1:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BOX (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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 SEX			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			
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 <input type="checkbox"/> F <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE			
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 ILLNESS (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 17a. _____ 17b. NPI			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____ 22. MEDICAID 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 OF UNITS H. FROST 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 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 _____				26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. NPI 33. BILLING PROVIDER INFO & PH # ()			

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Field 1:

1. MEDICARE		MEDICAID		TRICARE CHAMPUS		CHAMPVA		GROUP HEALTH PLAN		FECA BOK LUNG		OTHER		1a. INSURED'S I.D. NUMBER		(For Program in Item 1)	
<input type="checkbox"/> (Medicare #)		<input type="checkbox"/> (Medicaid #)		<input type="checkbox"/> (Sponsor's SSN)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (SSN or ID)		<input type="checkbox"/> (SSN)		<input checked="" type="checkbox"/> (ID)					
2. PATIENT'S NAME (Last Name First Name Middle Initial)				3. PATIENT'S BIRTH DATE				4. INSURER'S NAME (Last Name First Name Middle Initial)									

1: Always mark the "OTHER" box. This informs the insurer that this is a workers' compensation claim.

Field 1a: INSURED'S ID NUMBER:

<div>1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>											
<div> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> PICA </div> </div>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
3. PATIENT'S BIRTH DATE MM DD YY M F						7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					
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 <input type="checkbox"/> F <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE					
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 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 PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____ 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____ 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____						22. MEDICAID 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 EMG <input type="checkbox"/> <input type="checkbox"/> C. 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. #					
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 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. NPI _____ b. _____ 33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____					

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Field 1a: INSURED'S I.D. NUMBER:

1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
Put the worker's SSN here (if known)	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	

1a: Put the worker's social security number here (if it is known).

If worker does not have a SSN put five 9's (**99999**) in this box so the insurer knows you didn't just forget to put it in.

Note: this is different information than what is usually put in this box for a general health/Medicare claim.

Field 4: INSURED'S NAME:

1500											
HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>						1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)					
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY STATE						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:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME						11. INSURED'S POLICY GROUP OR FECA NUMBER					
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.						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 _____ DATE _____						SIGNED _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate 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 MM DD YY To MM DD YY B. RATE 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. EPST/ 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 gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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.)						32. SERVICE FACILITY LOCATION INFORMATION					
33. BILLING PROVIDER INFO & PH # ()						34. BILLING PROVIDER INFO & PH # ()					
SIGNED _____ DATE _____						SIGNED _____					

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Field 4: INSURED'S NAME:

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Put the employer's name here
7. INSURED'S ADDRESS (No. Street)

4: Put the employer's name here. For workers' compensation claims, the "insured" is the employer.

Field 7: INSURED'S ADDRESS:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ ☐ PICA ☐ ☐

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		c. INSURANCE PLAN NAME OR PROGRAM NAME	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
c. EMPLOYER'S NAME OR SCHOOL NAME		SIGNED _____	
d. INSURANCE PLAN NAME OR PROGRAM NAME		DATE _____	
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.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
SIGNED _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
DATE _____		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		23. PRIOR AUTHORIZATION NUMBER	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
19. RESERVED FOR LOCAL USE		25. FEDERAL TAX I.D. NUMBER SSN EIN	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		26. PATIENT'S ACCOUNT NO.	
1. _____ 3. _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. _____ 4. _____		28. TOTAL CHARGE \$	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		29. AMOUNT PAID \$	
1		30. BALANCE DUE \$	
2		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.)	
3		32. SERVICE FACILITY LOCATION INFORMATION	
4		33. BILLING PROVIDER INFO & PH # ()	
5		a. NPI b. NPI	
6		SIGNED _____	
DATE _____		DATE _____	

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Field 7: INSURED'S ADDRESS:

7. INSURED'S ADDRESS (No., Street) Put the employer's address here (include City, State, and Zip Code).		I N F O R M A T I O N
CITY	STATE	
ZIP CODE	TELEPHONE (Include Area Code) ()	
44. INSURER'S POLICY OR POLICY GROUP NUMBER		

7. Put the employer's address here; telephone number is also useful but not required.

Field 10: IS PATIENT'S CONDITION RELATED TO:

1500										CARRIER
HEALTH INSURANCE CLAIM FORM										PICA
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05										PICA
<div style="display: flex; justify-content: space-between;"> <div> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LUNG) <input type="checkbox"/> OTHER </div> </div> <div> <div> <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (ID) </div> </div> </div>										
1. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE					SEX
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED					7. INSURED'S ADDRESS (No., Street)
CITY					CITY					STATE
ZIP 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)					a. INSURED'S DATE OF BIRTH
b. OTHER INSURED'S DATE OF BIRTH					b. AUTO ACCIDENT?					SEX
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?					b. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					c. INSURANCE PLAN NAME OR PROGRAM NAME
<div style="display: flex; justify-content: space-between;"> <div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> <div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> </div>										
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<div style="display: flex; justify-content: space-between;"> <div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> <div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> </div>										
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Field 10: IS PATIENT'S CONDITION RELATED TO:

10: Always check the "YES" box under "a." EMPLOYMENT? (Current or Previous)".

If the injury was due to an automobile accident, check the "YES" box in "b. AUTO ACCIDENT?"

If the injury was due to an automobile accident, put the state where the automobile accident occurred under "PLACE" in "b".

10. IS PATIENT'S CONDITION RELATED TO:		1'
a. EMPLOYMENT? (Current or Previous)		a.
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	
b. AUTO ACCIDENT?		b.
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	
PLACE (State)		
MD		
c. OTHER ACCIDENT?		c.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	
10d. RESERVED FOR LOCAL USE		d.
IG & SIGNING THIS FORM.		12

Field 11: INSURED'S POLICY GROUP OR FECA NUMBER:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ PICA ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LINC) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH	
b. OTHER INSURED'S DATE OF BIRTH		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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.		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		SIGNED	
DATE		DATE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	
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 OR INJURY (Relate 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 C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. I.D. 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)		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.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH #			
SIGNED		SIGNED	
DATE		DATE	

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11: INSURED'S POLICY GROUP OR FECA NUMBER:

11. INSURED'S POLICY GROUP OR FECA NUMBER		JRED INFC
Put the worker's compensation claim number here (if known).		
a. INSURED'S DATE OF BIRTH	SEX	

11: Put the workers' compensation claim number here (if known).

Field 11c: INSURANCE PLAN NAME OR PROGRAM NAME:

1500										CARRIER	
HEALTH INSURANCE CLAIM FORM										PICA	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)			
CITY				STATE				CITY			
ZIP CODE				TELEPHONE (Include Area Code)				ZIP CODE			
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				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. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				SEX M <input type="checkbox"/> F <input type="checkbox"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				c. INSURANCE PLAN NAME OR PROGRAM NAME			
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: ILLNESS (First symptom) 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				17a. NPI				FROM MM DD YY TO MM DD YY			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE				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 OF UNITS				H. EPISODE Family Plan				I. ID. QUAL.			
J. RENDERING PROVIDER ID. #				K. NPI				L. NPI			
25. FEDERAL TAX I.D. NUMBER				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____				a. NPI				b. NPI			

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Field 11c: INSURANCE PLAN NAME OR PROGRAM NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME	11c
Put the employer's department or division (if different from box 4)	

11c: Put the Workers' Compensation employer department or division here (if different from box 4).

Field 17: NAME OF REFERRING PROVIDER:

1500										CARRIER	
HEALTH INSURANCE CLAIM FORM										PICA	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
PICA										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>				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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)					
CITY				STATE		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)		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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?					
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.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR (Reserve for local use)					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				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					
17a. NPI				17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE		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		E. DIAGNOSIS POINTER	
25. FEDERAL TAX I.D. NUMBER				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	
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.)				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #					
SIGNED				DATE		a. NPI		b. NPI			

Field 17: NAME OF REFERRING PROVIDER:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		1
Put the name of the Referring Provider here		1
18. RESERVED FOR LEGAL USE		

17: Put the name of the referring provider here.

Fields 17a & 17b: REFERRING PROVIDER'S NPI and TAXONOMY CODE:

1500										CARRIER	
HEALTH INSURANCE CLAIM FORM										PICA	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
<div> <div> <input type="checkbox"/> MEDICARE (Medicare #) </div> <div> <input type="checkbox"/> MEDICAID (Medicaid #) </div> <div> <input type="checkbox"/> TRICARE (Sponsor's SSN) </div> <div> <input type="checkbox"/> CHAMPVA (Member ID#) </div> <div> <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) </div> <div> <input type="checkbox"/> FECA (SSN) </div> <div> <input type="checkbox"/> OTHER (ID) </div> </div>										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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code)		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
d. INSURANCE PLAN NAME OR PROGRAM NAME				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	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> 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				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO				\$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate 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 MM DD YY To MM DD YY				B. PLACE OF SERVICE			
25. FEDERAL TAX I.D. NUMBER				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (If not claim, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()			
SIGNED				DATE				a. NPI			
								b. TAXONOMY CODE			

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Fields 17a & 17b: REFERRING PROVIDER'S NPI and TAXONOMY CODE:

When using the taxonomy code, put the required "ZZ" qualifier here.

17a.		Put the referring provider taxonomy number here.	1
17b.	NPI	Put the referring provider NPI number here.	2

17a: Put the referring provider's taxonomy number here. Put "ZZ" as the qualifier when using the referring provider's taxonomy number.

17b: Put the referring provider's NPI number here.

Note: If you do not have the referring provider's NPI number, do not report the provider's taxonomy number.

If the referring provider doesn't have an NPI, put the referring provider's state license number in box 17a. Put "0B" as the qualifier in this field when using the provider's state license number.

Field 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. M C
1. 922		3. 722		23. P
2. 922.3		4. 722.51		
24. A DATE(S) OF SERVICE				
B C D DOCTOR/PROVIDER SERVICES OR SUPPLIES				
E				

21: Each space must be completed with a correct ICD-9-CM code. Use the ICD-9-CM, 9th Revision book for codes and all applicable digits.

Note: If the 5th digit applies, you must use it here.

Examples from the ICD-9-CM book:

922.3

- 922 - contusion of the trunk
- .3 - contusion of the back (more specific)

722.51

- 722 - intervertebral disc disorders
- .5 - degeneration of thoracic or lumbar intervertebral disc
- .51 - thoracic or thoracolumbar intervertebral disc

Field 24: specifically 24J: RENDERING PROVIDER I.D. NUMBER:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ ☐ PICA ☐ ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY	STATE	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)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
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: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain if unusual circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS H. EPSDT I. IN J. RENDERING PROVIDER I.D. #		23. PRIOR AUTHORIZATION NUMBER	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO (If not gvt. claim, see back)		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. NPI b. _____	
33. BILLING PROVIDER INFO & PH # () a. NPI b. _____			

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Field 24: specifically 24J: RENDERING PROVIDER I.D. NUMBER:

Put rendering taxonomy code here
Put the corresponding "ZZ" qualifier here

24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.	PHYSICIAN OR SUPPLIER INFORMATION
From To										EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES	DAYS OR	SPRINT	QUAL.	RENDERING PROVIDER ID. #			
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	POINTER														
1																		NPI					
2																		NPI					
3																		NPI					
4																		NPI					
5																		NPI					
6																		NPI					
7																		NPI					

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

Put the rendering NPI number here

24J: In the upper shaded box put the rendering taxonomy number. Use "ZZ" as the qualifier in box 24I.
Put the NPI number in the NPI box.

Note: If no NPI number is available for rendering provider, do not use the taxonomy number. Put the rendering provider's state license number in the upper shaded box of 24J and use "0B" in box 24I for the qualifier.

Field 25: FEDERAL TAX I.D. NUMBER:

25. FEDERAL TAX I.D. NUMBER	SSN	EIN
Billing provider Fed. Tax ID no. here	<input type="checkbox"/>	<input checked="" type="checkbox"/>
34 SIGNATURE OF PHYSICIAN OR SUBMITTED		

25: Put the Federal Tax I.D. number of the billing provider (the one being paid) here.

Field 32: (specifically 32a and 32b) SERVICE FACILITY LOCATION INFORMATION:

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>																																																																																																																							
<div style="float: right;">CARRIER</div> <div style="float: right;">PICA <input type="checkbox"/></div>																																																																																																																							
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/></p> <p><small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (ID)</small></p> </div> <div style="width: 55%;"> <p>1a. INSURED'S I.D. NUMBER (For Program in Item 1)</p> </div> </div>																																																																																																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																													
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																																																																																																													
CITY				STATE				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)				a. INSURED'S DATE OF BIRTH				SEX																																																																																																											
b. OTHER INSURED'S DATE OF BIRTH				b. AUTO ACCIDENT?				b. EMPLOYER'S NAME OR SCHOOL NAME				M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																											
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT?				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 <input type="checkbox"/> NO <input type="checkbox"/> <small>If yes, return to and complete item 9 a-d.</small>																																																																																																											
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p> <p>SIGNED _____ DATE _____</p>																																																																																																																							
<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>																																																																																																																							
14. DATE OF CURRENT: ILLNESS (First symptom) 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				FROM TO																																																																																																											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				FROM TO																																																																																																											
19. RESERVED FOR LOCAL USE				17b. NPI				20. OUTSIDE LAB? \$ CHARGES				YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)																																																																																																																							
<div style="display: flex; justify-content: space-between;"> <div>1. _____</div> <div>3. _____</div> </div>																																																																																																																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">24. A. DATE(S) OF SERVICE</th> <th colspan="2">B. PLACE OF SERVICE</th> <th>C. EMG</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES</th> <th>E. DIAGNOSIS</th> <th>F. \$ CHARGES</th> <th>G. DAYS OF UNITS</th> <th>H. EPISODES</th> <th>I. ID. QUAL.</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th></th> <th></th> <th>(Explain Unusual Circumstances)</th> <th>POINTER</th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>												24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OF UNITS	H. EPISODES	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	From	To				(Explain Unusual Circumstances)	POINTER						MM	DD	YY	MM	DD	YY							1												2												3												4												5												6											
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25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()																																																																																																															
SIGNED _____				a. NPI				b. NPI																																																																																																															

NUCC Instruction Manual available at: www.nucc.org

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Field 32: (specifically 32a and 32b) SERVICE FACILITY LOCATION INFORMATION:

32. SERVICE FACILITY LOCATION INFORMATION		33.
a. NPI # here	b. ZZ Taxonomy Code here	a.

www.nuoc.org

- 32a.** Put the service facility's NPI number.
- 32b.** Put the service facility's taxonomy code. Use "ZZ" as the qualifier ahead of the taxonomy code.

Note: If you do not use the service facility's NPI number, do not use the taxonomy code. Put the state license number in box 32b. Use "0B" as the qualifier ahead of the state license number.

Field 33: (specifically 33a & 33b) BILLING PROVIDER INFO & PH#:

33. BILLING PROVIDER INFO & PH # ()	
a. NPI # here	b. ZZ Taxonomy Code here

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33a. Put the billing provider's NPI number.

33b. Put the billing provider's taxonomy code. Use "**ZZ**" as the qualifier ahead of the taxonomy code.

Note: If you do not use the billing provider's NPI number, do not use the taxonomy code. Put their state license number in box 33b. Use "**0B**" as the qualifier ahead of the state license number.

CMS1500 Billing Tips RESOURCES

CMS1500 form information:

- 1) For information on the CMS 1500 form, go to the Centers for Medicare & Medicaid Services (CMS) Web site @

<http://www.cms.hhs.gov/CMSForms/>

Click on CMS Forms in the Overview Box, and go to CMS1500 form

- 2) For instructions on the CMS 1500, go to the National Uniform Claim Committee's Web site @ www.nucc.org. The NUCC regularly updates this site for revisions to the CMS 1500 instructions.

Workers' Compensation Division:

- 1) **Medical Section, Resolution Team:** 503.947.7606
Or toll free @ 1.800.452.0288, ask for the Medical Section, Resolution Team
- 2) **Employer Compliance Unit:** 503.947.7815 in Salem
Or toll free @ 888.877.5670

Workers' Compensation Division's Web site @

www.wcd.oregon.gov Find WCD's laws and rules on this same site.

For a direct link to the Health Care Provider's page, go to
www.oregonwcdoc.info

To find the employer's workers compensation insurance carrier, go to
www.wcd.oregon.gov and click on the "Employer Coverage" link under
"Business Tools"