CMS-1500 Form

CARRIER INFORMATION

Carrier information: _____

PATIENT AND INSURED INFORMATION

1. Select one:

- ◯ MEDICARE (Medicare#)
- ◯ TRICARE (ID#/DoD#)
- ◯ GROUP HEALTH PLAN (ID#)
- ◯ MEDICAID (Medicaid#)
- ◯ CHAMPVA (member ID#)
- ◯ FECA BLK LUNG (ID#)
- ◯ Other

1a. Insured's ID number (for program in item 1): _____ **2. Patient's name (Last name, first name, middle initial):** _____

3. Patient's birth date: _____ dd / mm / yyyy

Patient's sex:

◯ M ◯ F

4. Insured's name (Last name, first name, middle initial): _____

5. Patient's address:

City: _____ **State:** _____

Telephone: _____ **Zip:** _____

6. Patient's relationship to the insured:

◯ Self ◯ Spouse ◯ Child ◯ Other

7. Insured's address:

City: _____ **State:** _____

Telephone: _____ **Zip:** _____

8. Admin use only

9. Other insured's name (Last name, first name, middle initial): _____ **9a. Other insured's policy or group number:** _____

9b. Reserved for admin use

9c. Reserved for admin use

9d. Insurance plan name or program name: _____

10. Is patient's condition related to: a. Employment? (current or previous):

◯ Yes ◯ No

b. Auto accident?

◯ Yes ◯ No

Place (state): _____

c. Other accident?

◯ Yes ◯ No

10d. Claim codes: _____ **11. Insured's policy group or FECA number:** _____

11a. Insured's birth date: _____ dd / mm / yyyy

Insured's sex:

◯ M ◯ F

11b. Other claim ID: _____ **11c. Insurance plan name or program name:** _____

11d. Is there another health benefit plan?

◯ Yes ◯ No

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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.
Date: _____ dd / mm / yyyy

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13. Insured or authorized person's signature | I authorize payment or medical benefits to the undersigned physician or supplier for services described below.
Date: _____ dd / mm / yyyy

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of current illness, injury, or pregnancy (LMP): dd / mm / yyyy **15. Other date:** _____ dd / mm / yyyy

16. Dates patient unable to work in current occupation: _____ **17. Name of referring provider or other:** _____

17a.: _____ **17b. NPI:** _____

18. Hospitalization dates related to current services: _____

19. Additional claim information:

20. Outside lab?

◯ Yes ◯ No

$ Charges: _____

21. Diagnosis or nature of illness or injury (relate A-L to service line below (24E)

A.: _____ **B.:** _____

C.: _____ **D.:** _____

E.: _____ **F.:** _____

G.: _____ **H.:** _____

I.: _____ **J.:** _____

K.: _____ L.: _____

22. Resubmission code: _____ Original ref. no.: _____

23. Prior authorization number: _____

24.

1. a. Dates of service: _____ b. Place: _____

c. EMG: _____ d. Procedures, services or supplies: CPT/HCPCS: _____

Modifier: _____ e. Diagnosis pointer: _____

f. $ Charges: _____ g. Days or units: _____

h. EPSCT family plan: _____ i. ID Qual.: _____

j. Rendering provider ID#: _____ 25. Federal tax I.D. no.: _____

Select one:

◯ SSN ◯ EIN

26. Patient's account no.: _____

27. Accept assignment?

◯ Yes ◯ No

28. Total charge: _____ 29. Amount paid: _____

30. Reserved for admin use

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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.

Date: _____ dd / mm / yyyy

32. Service facility location information:

32a. NPI: _____ 32b.: _____

33. Billing provider info & Ph:

33a.: _____ 33b.: _____