

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Member Information

Coordination of Benefits

Indicators and Date of Onset

Code Rules

Provider Information – Unique ID (TPI# or CH#)

Practice Information

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 ID NUMBER (See Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE										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										8. PATIENT STATUS										CITY									
STATE										9. OTHER COB (Initial)										STATE									
ZIP CODE										10. IS PATIENT'S CONDITION RELATED TO:										ZIP CODE									
TELEPHONE (Include Area Code)										a. EMPLOYMENT? (Current or Previous)										TELEPHONE (Include Area Code)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										b. AUTO ACCIDENT?										11. INSURED'S DATE OF BIRTH									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										c. OTHER ACCIDENT?										MM DD YY									
b. OTHER INSURED'S DATE OF BIRTH										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE										SEX									
M DD YY										14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										M DD YY									
c. EMPLOYER'S NAME OR SCHOOL NAME										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE										MM DD YY									
SURANCE PLAN NAME OR PROGRAM NAME										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION										FROM TO									
10d. RESERVED FOR LOCAL USE										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI									
18. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES										FROM TO									
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										20. OUTSIDE LAB? \$ CHARGES										20. OUTSIDE LAB? \$ CHARGES									
1. Valid ICD-9										21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
2. Valid CPT/ Modifiers										22. PRIOR AUTHORIZATION NO. ONLY										22. PRIOR AUTHORIZATION NO. ONLY									
3. DX Pointer										23. DATE(S) OF SERVICE										23. DATE(S) OF SERVICE									
4. Taxonomy										24. PATIENT'S ACCOUNT NO.										24. PATIENT'S ACCOUNT NO.									
5. NPI										25. ACCEPT ASSIGNMENT? (For GRM items, see back)										25. ACCEPT ASSIGNMENT? (For GRM items, see back)									
6. NPI										26. TOTAL CHARGE										26. TOTAL CHARGE									
7. NPI										27. AMOUNT PAID										27. AMOUNT PAID									
8. NPI										28. BALANCE DUE										28. BALANCE DUE									
9. NPI										29. 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)										29. 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)									
10. NPI										30. SERVICE FACILITY LOCATION INFORMATION										30. SERVICE FACILITY LOCATION INFORMATION									
11. NPI										31. BILLING PROVIDER INFO & PHONE NO.										31. BILLING PROVIDER INFO & PHONE NO.									
12. NPI										32. PRACTICE TIN #										32. PRACTICE TIN #									
13. NPI										33. PRACTICE NAME OR FACILITY WHERE SERVICE ARE RENDERED										33. PRACTICE NAME OR FACILITY WHERE SERVICE ARE RENDERED									
14. NPI										34. NAME AND ADDRESS WHERE PAYMENTS WILL BE MAILED										34. NAME AND ADDRESS WHERE PAYMENTS WILL BE MAILED									
15. NPI										35. SIGNATURE OF PHYSICIAN OR SUPPLIER										35. SIGNATURE OF PHYSICIAN OR SUPPLIER									
16. NPI										36. DATE										36. DATE									

If Box 10 = Yes, Date Required

Referring Provider Name Taxonomy & NPI required

EPSDT Condition Indicator

EPSDT Benefit Code

EPSDT or Family Planning (Y or N)

Taxonomy

NPI

If Box 11d = Yes, Pay Amount Required

Attached EOB From Primary Insurance Required

NPI

Taxonomy