

# Revised CMS-1500 Health Insurance Claim Form (08/05)

Changes in Blue • Source of changes: [www.nuoc.org/images/stories/PDF/Revised\\_1500\\_change\\_08.pdf](http://www.nuoc.org/images/stories/PDF/Revised_1500_change_08.pdf)

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

**HEALTH ADVANTAGE, INC**  
**PO BOX 1511**  
**FLINT, MI 48501-1511**

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> THE STATE HEALTH PLAN (Members 2000) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP (See Part 1, Section 1) <input checked="" type="checkbox"/> OTHER PLAN (See Part 1, Section 1) <input type="checkbox"/> FECA (See Part 1, Section 1) <input type="checkbox"/> OTHER <input type="checkbox"/>										14. INSURER'S ID NUMBER (Per Program Item 1) <b>555-55-0055</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Smith, Ann G</b>					3. PATIENT'S BIRTH DATE (MM   DD   YY) <input type="checkbox"/> SEX <input type="checkbox"/>					4. INSURER'S NAME (Last Name, First Name, Middle Initial) <b>Smith, Ann G</b>	
5. PATIENT'S ADDRESS (No. Street) <b>1234 Anywhere Ave</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURER'S ADDRESS (No. Street) <b>1234 Anywhere Ave</b>	
8. CITY <b>Okemos</b>			9. STATE <b>MI</b>		10. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			11. CITY <b>Okemos</b>		12. STATE <b>MI</b>	
ZIP CODE <b>48864</b>		TELEPHONE (Include Area Code) <b>(517) 555-5555</b>			13. EMPLOYER'S NAME OR SCHOOL NAME <b>BCCCP</b>		14. INSURER'S DATE OF BIRTH (MM   DD   YY) <input type="checkbox"/> SEX <input type="checkbox"/>		15. EMPLOYER'S NAME OR SCHOOL NAME <b>BCCCP</b>		
16. OTHER INSURER'S NAME (Last Name, First Name, Middle Initial)					17. EMPLOYER'S NAME OR SCHOOL NAME					18. INSURANCE PLAN NAME OR PROGRAM NAME <b>BCCCP</b>	
19. OTHER INSURER'S POLICY OR GROUP NUMBER					20. EMPLOYMENT (Current or Former) <input type="checkbox"/> YES <input type="checkbox"/> NO					19. INSURANCE PLAN NAME OR PROGRAM NAME <b>BCCCP</b>	
21. OTHER INSURER'S DATE OF BIRTH (MM   DD   YY) <input type="checkbox"/> SEX <input type="checkbox"/>					22. AUTO ACCIDENT? PLACE (State) _____					20. INSURER'S DATE OF BIRTH (MM   DD   YY) <input type="checkbox"/> SEX <input checked="" type="checkbox"/>	
23. EMPLOYER'S NAME OR SCHOOL NAME					23. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					21. EMPLOYER'S NAME OR SCHOOL NAME <b>BCCCP</b>	
24. INSURANCE PLAN NAME OR PROGRAM NAME					24. SEE RECEIVED FOR LOCAL USE					22. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 2 and 4.	
READ BACK OF FORM BEFORE COMPLETING A RECURRING CLAIM.										23. INSURER'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of government benefits either to myself or to the party who accepts assignment.)	
<b>SIGNATURE ON FILE</b>										<b>SIGNATURE ON FILE</b>	
25. DATE OF CURRENT CLAIM (MM   DD   YY)					26. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (Give Month and Year) (MM   DD   YY)					24. INSURER'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services rendered to this patient.)	
27. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					28. PHYSICIAN IDENTIFICATION NUMBER (See Part 1, Section 1)					25. DATE OF CURRENT CLAIM (MM   DD   YY)	
29. RESERVED FOR LOCAL USE					29. PHYSICIAN IDENTIFICATION NUMBER (See Part 1, Section 1) <b>1346269644</b>					26. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (Give Month and Year) (MM   DD   YY)	
30. EXPOSURE OR NATURE OF ILLNESS OR INJURY (Specify Item 1, 2, 3 or 4 as appropriate by code)										27. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
1. <b>V72.31</b>										30. EXPOSURE OR NATURE OF ILLNESS OR INJURY (Specify Item 1, 2, 3 or 4 as appropriate by code)	
31. DATE OF SERVICE (MM   DD   YY)										28. PHYSICIAN IDENTIFICATION NUMBER (See Part 1, Section 1)	
03   06   07   11   99213										28. PHYSICIAN IDENTIFICATION NUMBER (See Part 1, Section 1) <b>1346269644</b>	
32. PROCEDURE, SERVICE, OR SUPPLY (Specify ICD-9-CM or HCPCS code)										29. RESERVED FOR LOCAL USE	
77.00   1										29. RESERVED FOR LOCAL USE	
33. FEDERAL TAX ID NUMBER (SEE INSTRUCTIONS)										31. DATE OF SERVICE (MM   DD   YY)	
382853534										31. DATE OF SERVICE (MM   DD   YY) 03   06   07	
34. PATIENT'S ACCOUNT NO.										32. PROCEDURE, SERVICE, OR SUPPLY (Specify ICD-9-CM or HCPCS code)	
1234500										32. PROCEDURE, SERVICE, OR SUPPLY (Specify ICD-9-CM or HCPCS code) 77.00   1	
35. ACCOUNT TYPE (See Part 1, Section 1)										33. FEDERAL TAX ID NUMBER (SEE INSTRUCTIONS)	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										33. FEDERAL TAX ID NUMBER (SEE INSTRUCTIONS) 382853534	
36. TOTAL CHARGE										34. PATIENT'S ACCOUNT NO.	
\$ 77.00										34. PATIENT'S ACCOUNT NO. 1234500	
37. AMOUNT PAID										35. ACCOUNT TYPE (See Part 1, Section 1)	
\$ 00										35. ACCOUNT TYPE (See Part 1, Section 1) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
38. BALANCE DUE										36. TOTAL CHARGE	
\$ 77.00										36. TOTAL CHARGE \$ 77.00	
39. SIGNATURE OF PHYSICIAN OR SUPPLIER (Indicate address on credentialing form to verify that the address on the invoice copy is correct, but you need not include a post office.)					40. PHYSICIAN IDENTIFICATION NUMBER (See Part 1, Section 1)					37. AMOUNT PAID	
RICHARD, ROBERT					WESTSIDE HEALTH CENTER					37. AMOUNT PAID \$ 00	
08/27/2007					669 STOCKING NW					38. BALANCE DUE	
08/27/2007					GRAND RAPIDS, MI 49504					38. BALANCE DUE \$ 77.00	
08/27/2007					1558459164					39. SIGNATURE OF PHYSICIAN OR SUPPLIER (Indicate address on credentialing form to verify that the address on the invoice copy is correct, but you need not include a post office.)	
08/27/2007					1558459164					39. SIGNATURE OF PHYSICIAN OR SUPPLIER (Indicate address on credentialing form to verify that the address on the invoice copy is correct, but you need not include a post office.) RICHARD, ROBERT	

CARRIER  
 PATIENT AND RESURD INFORMATION  
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# Place Of Service Codes For Cms 1500

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