

1500 Claim Form Instructions

Items 1 Through 13 Patient Data

This tool provides a quick overview of a few important fields in the claim form. Each number listed below provides direction to the corresponding numbered field within the claim form. For detailed instructions please consult the **NUCC Guide**.

- 1** Select type of insurance; place X in the appropriate box.
- 2** Enter the patient's full name EXACTLY as it appears on their card.
- 5** Enter patient's mailing address and telephone #.
- 6** Place X in the box that indicates patient's relationship to insured when Item # 4 is not the same as your patient.
- 1A** Enter insured's ID # EXACTLY as it appears on the card or the Claim # for WC or PI.

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

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DOD #) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA (FECA/Long (ID#) OTHER (ID#)

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) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED (Self | Spouse | Child | Other)

7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY 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 as signatory 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.

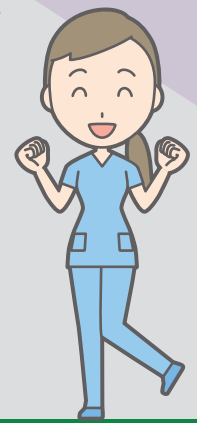
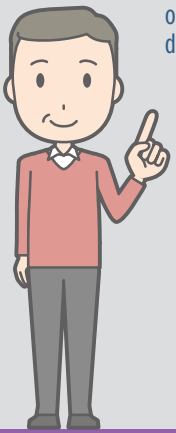
9 If field 11d indicates your patient has other coverage, complete fields 9, 9a, and 9d, otherwise leave blank.

11 Enter the insured's identifier as it appears on the insured's card, auto, or other coverage. If field 4 is completed, then this field should be completed. NOTE: Date of Birth must be in 8-digit format with spaces (MM | DD | CCYY)

10A-10C Place X for service related to Job Injury, Auto Accident, or Other Accident. Where the Accident occurred must be identified (2 digits) if 'YES' is marked in 10B.

12 Enter "Signature on File," and the date signed in 6-digit (MM/DD/YY) or 8-digit format (MM/DD/CCYY), indicating patient's signature is on file and clinic is authorized to release required information for processing claim.

11D If your patient has other coverage, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d.



1500 Claim Form Instructions

Items 14 Through 33

Provider Data

14

Enter one continuous 8 digit number (MMDDCCYY) without spaces for Items 14, 16, 18, 19 and 24a

24B

Enter the two-digit Place of Service Code (list can be found at www.cms.gov)
Example: Office-11

19

Refer to public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field.

21

Enter diagnosis and applicable ICD indicator: 0 for ICD-10.

22

IF resubmitting a claim, enter the bill frequency code: 7 Replacement of prior claim, 8 Void/cancel of prior claim. (Leave blank for Medicare.)

24G

Enter the number of units.

24J

The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

24E

Enter the diagnosis pointer from field 21 to link a diagnosis code to the CPT performed.

32

Enter the name, address, city, state, and ZIP code of the location where the services were rendered.

25

Enter the "Federal Tax ID Number" of the Billing Provider identified in Item #33.

27

Place X in the correct box; indicates that the provider agrees to accept assignment under the terms of the payer's program.

31

Enter the legal signature of the practitioner, or "Signature on File," or "SOF."

33

Enter the provider's billing name, address, ZIP code, and phone number.

32A

Enter the NPI number of the service facility location. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE QUAL. MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD TO MM DD	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD TO MM DD	
19. ADDITIONAL CLAIM INFORMATION (Designated NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD Ind. B. ICD Ind. C. ICD Ind. D. ICD Ind. E. ICD Ind. F. ICD Ind. G. ICD Ind. H. ICD Ind. I. ICD Ind. J. ICD Ind. K. ICD Ind. L. ICD Ind.				22. RESUBMISSION ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		C. ICD CODE EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For prior claims, see instructions) <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (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. NPI		33. BILLING PROVIDER INFO & PH # () a. NPI b. NPI	

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

