

DISCLAIMER: information referenced is based on current crosswalk availability and is subject to change

HEALTH INSURANCE CLAIM FORM

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 BLK LUNG <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"/>	
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		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		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		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.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED DATE		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		b. EMPLOYER'S NAME OR SCHOOL NAME	
MM DD YY		c. INSURANCE PLAN NAME OR PROGRAM NAME	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		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.	
MM DD YY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		SIGNED	
17a. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17b. NPI LOOP 2310A or 2420F - Line Level		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <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 ORIGINAL REF. NO.	
1. _____ 3. _____		23. PRIOR AUTHORIZATION NUMBER	
2. _____ 4. _____		F. \$ CHARGES	
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) E. DIAGNOSIS POINTER		G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
1		2	
2		NPI LOOP 2310B or LOOP 2420A - Line Level	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER LOOP2010AA or LOOP 2010AB - Line level SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
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.)		29. AMOUNT PAID \$	
32. SERVICE FACILITY LOCATION INFORMATION		30. BALANCE DUE \$	
SIGNED DATE		33. BILLING PROVIDER INFO & PH # ()	
a. LOOP2310D or LOOP 2420C - Line level b.		a. LOOP2010AA b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

- Report the referring physician NPI number (2310A or 2420F; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)
- Report NPI for rendering physician if applicable (2310B or 2420A; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)
- After mandate use the nine-byte EIN only when filing to BlueCross BlueShield of South Carolina (2010AA or 2010AB)
- Report NPI of facility/group where services were rendered (2310D or 2420C; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)
- Report NPI of facility/group where services were billed (2010AA; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)