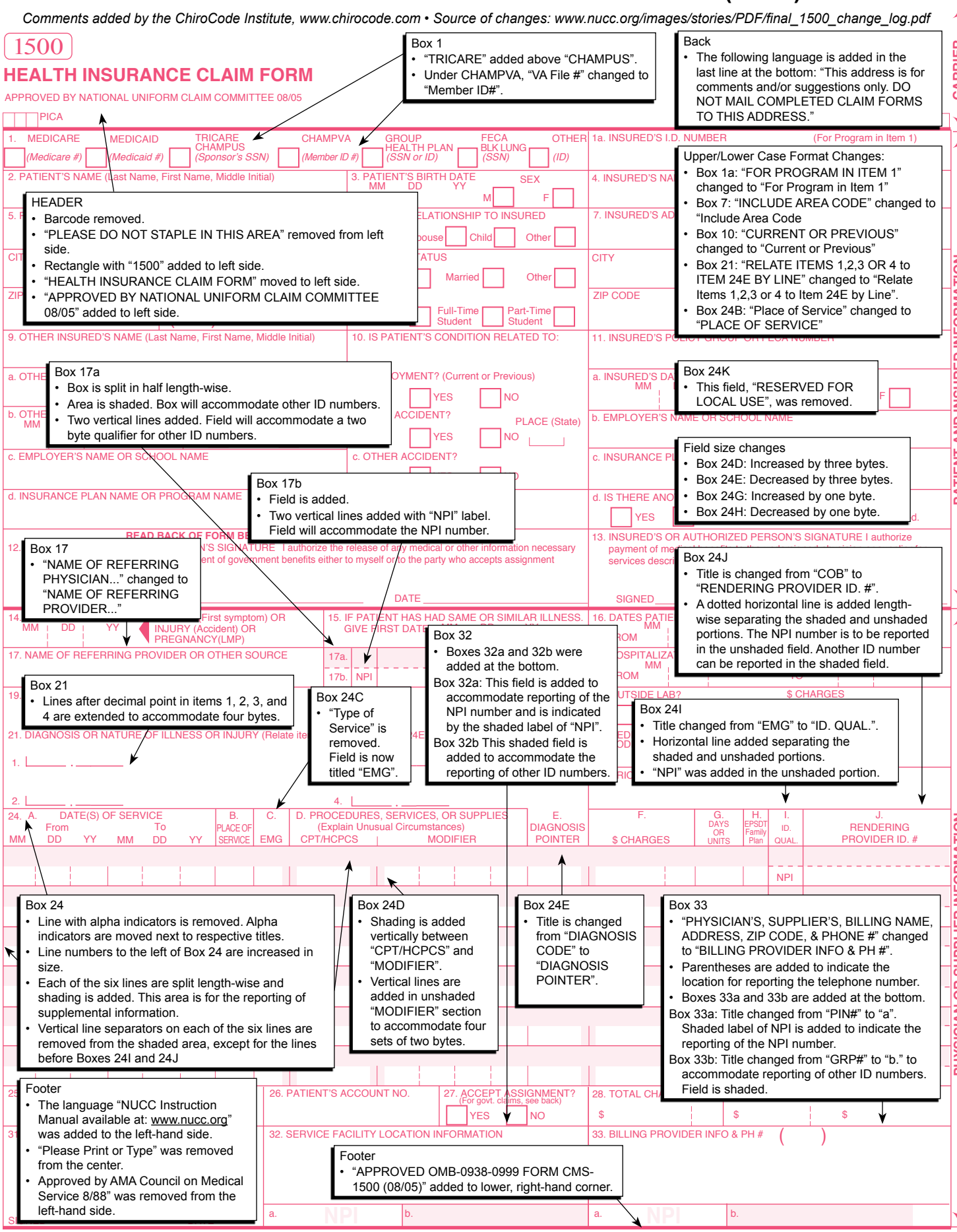
Revised CMS-1500 Health Insurance Claim Form (08/05)

Comments added by the ChiroCode Institute, www.chirocode.com • Source of changes: www.nucc.org/images/stories/PDF/final_1500_change_log.pdf



Box 1
- "TRICARE" added above "CHAMPUS".
- Under CHAMPVA, "VA File #" changed to "Member ID#".

Back
- The following language is added in the last line at the bottom: "This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS."

HEADER
- Barcode removed.
- "PLEASE DO NOT STAPLE IN THIS AREA" removed from left side.
- Rectangle with "1500" added to left side.
- "HEALTH INSURANCE CLAIM FORM" moved to left side.
- "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05" added to left side.

Upper/Lower Case Format Changes:
- Box 1a: "FOR PROGRAM IN ITEM 1" changed to "For Program in Item 1"
- Box 7: "INCLUDE AREA CODE" changed to "Include Area Code
- Box 10: "CURRENT OR PREVIOUS" changed to "Current or Previous"
- Box 21: "RELATE ITEMS 1,2,3 OR 4 to ITEM 24E BY LINE" changed to "Relate Items 1,2,3 or 4 to Item 24E by Line".
- Box 24B: "Place of Service" changed to "PLACE OF SERVICE"

Box 17a
- Box is split in half length-wise.
- Area is shaded. Box will accommodate other ID numbers.
- Two vertical lines added. Field will accommodate a two byte qualifier for other ID numbers.

Box 24K
- This field, "RESERVED FOR LOCAL USE", was removed.

Box 17b
- Field is added.
- Two vertical lines added with "NPI" label. Field will accommodate the NPI number.

Field size changes
- Box 24D: Increased by three bytes.
- Box 24E: Decreased by three bytes.
- Box 24G: Increased by one byte.
- Box 24H: Decreased by one byte.

Box 17
- "NAME OF REFERRING PHYSICIAN..." changed to "NAME OF REFERRING PROVIDER..."

Box 24J
- Title is changed from "COB" to "RENDERING PROVIDER ID. #".
- A dotted horizontal line is added length-wise separating the shaded and unshaded portions. The NPI number is to be reported in the unshaded field. Another ID number can be reported in the shaded field.

Box 21
- Lines after decimal point in items 1, 2, 3, and 4 are extended to accommodate four bytes.

Box 24C
- "Type of Service" is removed. Field is now titled "EMG".

Box 32
- Boxes 32a and 32b were added at the bottom.

Box 32a: This field is added to accommodate reporting of the NPI number and is indicated by the shaded label of "NPI".

Box 32b This shaded field is added to accommodate the reporting of other ID numbers.

Box 24I
- Title changed from "EMG" to "ID. QUAL.".
- Horizontal line added separating the shaded and unshaded portions.
- "NPI" was added in the unshaded portion.

Box 24
- Line with alpha indicators is removed. Alpha indicators are moved next to respective titles.
- Line numbers to the left of Box 24 are increased in size.
- Each of the six lines are split length-wise and shading is added. This area is for the reporting of supplemental information.
- Vertical line separators on each of the six lines are removed from the shaded area, except for the lines before Boxes 24I and 24J

Box 24D
- Shading is added vertically between "CPT/HCPCS" and "MODIFIER".
- Vertical lines are added in unshaded "MODIFIER" section to accommodate four sets of two bytes.

Box 24E
- Title is changed from "DIAGNOSIS CODE" to "DIAGNOSIS POINTER".

Box 33
- "PHYSICIAN'S, SUPPLIER'S, BILLING NAME, ADDRESS, ZIP CODE, & PHONE #" changed to "BILLING PROVIDER INFO & PH #".
- Parentheses are added to indicate the location for reporting the telephone number.
- Boxes 33a and 33b are added at the bottom.

Box 33a: Title changed from "PIN#" to "a". Shaded label of NPI is added to indicate the reporting of the NPI number.

Box 33b: Title changed from "GRP#" to "b." to accommodate reporting of other ID numbers. Field is shaded.

Footer
- The language "NUCC Instruction Manual available at: www.nucc.org" was added to the left-hand side.
- "Please Print or Type" was removed from the center.
- Approved by AMA Council on Medical Service 8/88" was removed from the left-hand side.

Footer
- "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" added to lower, right-hand corner.

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

Changes in blue added by the ChiroCode Institute, www.chirocode.com • Source of changes: www.nucc.org/images/stories/PDF/final_1500_change_log.pdf

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

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 ☐ F ☐

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 ot Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.