

# CMS-1500 Claim Form – Physician Services

**Box 21:** Enter the appropriate ICD-9-CM diagnosis code

**Box 24D** Enter the appropriate CPT codes.  
Example:  
61517 (Implantation of brain intracavitary chemotherapy agent)

**Box 24I-J:** National Provider Identifier

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08.05

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1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS (Spouse's SSN)	CHAMPVA (Member ID)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	14. INSURED'S I.D. NUMBER (For Programs 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"/>	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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) CITY STATE 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. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		10d. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME										
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 _____ DATE _____		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24I by Line) 1. _____ 2. _____ 3. _____ 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 I MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF CHARGE	H. SPOT FEE/Flat Fee	I. ID. QUAL	J. RENDERING PROVIDER ID. #	1	2	3	4	5	6		
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. only) <input type="checkbox"/> YES <input type="checkbox"/> 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. _____						

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24D

24I-J