

CMS-1500 Claim Form (Physician Services)

Box 21: Enter the appropriate ICD-10-CM diagnosis code(s)

Box 24D: Enter the appropriate CPT code(s)

Example:

61510 (Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma)
 + 61517 (Implantation of brain intracavitary chemotherapy agent **Note:** 61517 is an add-on code; report 61517 in conjunction with 61510 or 61518)

Box 24I-J: National Provider Identifier

ICD-10-CM Diagnosis Code Cross Walk

ICD-10-CM Code	Code Description
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C71.9	Malignant neoplasm of brain, unspecified

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

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA (SECLUNG) (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) _____

6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other

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

8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO: (a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? (PLACE STATE) YES NO c. OTHER ACCIDENT? YES NO d. CLAIM CODES (Designated by NUCC) _____)

11. INSURED'S POLICY GROUP 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 assignment 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.)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD YY) _____

15. OTHER DATE (MM DD YY) _____

16. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a. _____ 17b. NPI _____)

17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

20. OUTSIDE LAB? YES NO # CHARGES _____

21. ICD-10-CM CODE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) (ICD Incl. _____)

22. 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 (BRAC) (EMG) C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) (MODIFIER) E. DIAGNOSIS POINTER F. # CHARGES G. DAYS ON LIFE H. HPT/ Pch Per I. SL. QUAL. J. RENDERING PROVIDER ID. #

25. FEDERAL TAX ID. NUMBER _____ SSN EIN _____

26. PATIENT'S ACCOUNT NO. _____

27. ACCEPT ASSIGNMENT? (For gov. benefit, see back) YES NO

28. TOTAL CHARGE \$ _____

29. AMOUNT PAID \$ _____

30. Field for NUCC Use _____

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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # () _____

SIGNED _____ DATE _____

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