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CMS-1500 Health Insurance Claim

HEALTH INSURANCE CLAIM FORM

Health Insurance Claim Form

1. MEDICARE

☑ **(Medicare #)**

MEDICAID

☑ **(Medicaid #)**

CHAMPUS

☐ **(Sponsor´s SSN)**

CHAMPVA

☐ **(VA Dile #)**

GROUP HEALTH PLAN

☐ **(SSN or ID)**

FECA BLK LUNG

☐ **(SSN)**

OTHER

☐ **(ID)**

data health insurance claim

1a. INSURED´S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

1234-5678MM

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Cunningham, Richard L.

3. PATIENT'S BIRTH DATE

07/25/1962

SEX

M

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

Cunningham, Richard L.

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

123 Oak Drive

CITY

McLean

STATE

Virginia

ZIP CODE

22044

TELEPHONE (Include Area Code)

703-867-5309

6. PATIENT RELATIONSHIP TO INSURED

☑ **Self**

☐ **Spouse**

☐ **Child**

☐ **Other**

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

123 Oak Drive

CITY

McLean

STATE

VA

ZIP CODE

22044

TELEPHONE (INCLUDE AREA CODE)

703-867-5309

Patient Status

8. PATIENT STATUS

Married

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

Cunningham, Angela

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)

c. OTHER ACCIDENT?

NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

1234-5678MM

a. INSURED'S DATE OF BIRTH

b. EMPLOYER'S NAME OR SCHOOL NAME

American Auto Care

c. INSURANCE PLAN NAME OR PROGRAM NAME

Medicare

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES

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NO

b. AUTO ACCIDENT? PLACE (State)

NO

07/25/1962

SEX

M

In yes, return to and complete item 9 a-d.

PATIENT'S OR AUTHORIZED

DATE

11/15/2019

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessaryto process this claim. I also request payment of government benefits either to myself or to the party who accepts assignmentbelow.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorizepayment of medical benefits to the undersigned physician or supplier forservices described below.

DATE OF CURRENT

14. DATE OF CURRENT:

11/15/2019

ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION TO:

11/14/2019

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Marcus Welby

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES TO

11/12/2019

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

YES

$ CHARGES

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11/01/2019

987832

$75.00

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM

11/02/2019

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM

11/06/2019

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1.

Congestive Heart Failure

2.

Pneumonia

3.

4.

22. MEDICAID RESUBMISSION CODE

356897

ORIGINAL REF. NO.

7895821

23. PRIOR AUTHORIZATION NUMBER

45687459AM

Date, Place Type Procedures Services

A. DATE(S) OF SERVICE	From	To	B. Place of Service	C. Type of Service	D. PROCEDU SERVICE OR SUPPLIE (Explain Unusual Circumsta	CPT/ HCPCS	MODIFIEF	E. DIAGNOS CODE	F. CHARGE
11/1/2019	11/01/2019	11/01/2019	Primary Care Doctors of Northern VA	Sick Visit	D. PROCEDUF SERVICES, OR SUPPLIES (Explain Unusual Circumstanc	CPT	2	4568789	$25.00 1
11/6/2019	11/06/2019	11/12/2019	Northern Virginia Doctors Hospital	Inpatient Hospital Care	D. PROCEDUF SERVICES, OR SUPPLIES (Explain Unusual Circumstanc	HPCS	B	4567896	$250.00 6

Data Total

25. FEDERAL TAX I.D. NUMBER

SSN

28. TOTAL CHARGE $

$325.00

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26. PATIENT'S ACCOUNT NO.
587-999-5309
27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
YES

29. AMOUNT PAID $
$25.00
30. BALANCE DUE $
$300.00

SIGNATURE

DATE
11/15/2019

31. SIGNATURE OF PHYSICIAN OR SUPPLIERINCLUDING DEGREES OR CREDENTIALS(I certify that the statements on the reverseapply to this bill and are made a part thereof.)

NAME AND ADDRESS OF FACILITY WHERE SERVICES

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE
RENDERED (If other than home or office)
333 South Carlin Springs Road Arlington, VA 22204
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIN #
78974564

GRP #
46546
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS. NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. REFERS TO GOVERNMENT PROGRAMS ONLY MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete.

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In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11. BLACK LUNG AND FECA CLAIMS The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems. SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG) I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or