Sample CMS-1500 Claim Form for Office Billing

	PICA	,	NUCC) 02/12						PICA	
	MEDICARE MEDICAID		CHAMPVA	GROUP F	BIKTUNG	1a. INSURED'S I.D. NU	MBER	(For Prog	gram in Item 1)	<u> </u>
	(Medicare#) (Medicaid#)		Member ID#)	(ID#)(ID#) [ID#)					_
	2. PATIENT'S NAME (Last Name, Fi	st Name, Middle Initial)	(B. PATIENT'S BIRTH DATE	SEX M F	4. INSURED'S NAME (L	ast Name, First Nar	ne, Middle Initia	al)	
	5. PATIENT'S ADDRESS (No., Stree	rt)		B. PATIENT RELATIONSHI		7. INSURED'S ADDRES	SS (No., Street)			-
				Self Spouse (Child Other					
	CITY		STATE 8	B. RESERVED FOR NUCC	USE	CITY			STATE	N _O
	ZIP CODE	TELEPHONE (Include A	Area Code)			ZIP CODE	ITE	EPHONE (Inc.	lude Area Code)	INFORMATION
	2.1 0052	()	rada dodd)			2 3352	()	ado / ii od oodo)	ORIV
	9. OTHER INSURED'S NAME (Last	Name, First Name, Middle	e Initial)	0. IS PATIENT'S CONDIT	ON RELATED TO:	11. INSURED'S POLICY	GROUP OR FECA	NUMBER		⊣ ≝
										a
	a. OTHER INSURED'S POLICY OR	GROUP NUMBER	ā	a. EMPLOYMENT? (Currer		a. INSURED'S DATE OF	F BIRTH YY		EX - 🖂	INSURED
	b. RESERVED FOR NUCC USE			YES D. AUTO ACCIDENT?	NO BLACE (Out)	b. OTHER CLAIM ID (D	esignated by NUCC	м 📗	F	Ž
				YES	PLACE (State)		, , , , , , , , , , , , , , , , , , , ,			AND
				c. OTHER ACCIDENT?		c. INSURANCE PLAN N	IAME OR PROGRA	M NAME		⊢ Ka
19				YES Od. CLAIM CODES (Desid	NO NO	d. IS THERE ANOTHER	HEALTH DENEST	DLANG		PATIENT
				TOG. CLAIM CODES (Desig	nated by NUCC)		NO <i>If yes</i> , com		la and Od	ļ.,
	s may require drug nar tion, NDC, and/or dos	aga ta ba	COMF				DRIZED PERSO	N'S SIGNATUR	E I authorize	$\dashv \mid$
	Box 19. Check with you		autho nt bend	OX 21			nefits to the unde w.	rsigned physici	an or supplier for	
y require		i payer to	•	Enter appropria	te diagnosis co	nde(s)				
,										<u> </u>
	14. DATE OF CURRENT ILLNESS, I	INJURY, or PREGNANCY	(LMP) 15. OT		DD YY	16. DATES PATIENT UN FROM MM DD	NABLE TO WORK IN	CURRENT O	DD YY	↑
	14. DATE OF CURRENT ILLNESS, I MM DD YY QUA		QUAL		DD YY	16. DATES PATIENT UN FROM MM DD				_ ^
	17. NAME OF REFERRING PROVID	DER OR OTHER SOURCE	E 17a.		DD YY	18. HOSPITALIZATION FROM MM DD	DATES RELATED T	O CURRENT S		_
	I GOA	DER OR OTHER SOURCE	E 17a.	MM	DD YY	18. HOSPITALIZATION FROM MM DD 20. OUTSIDE LAB?		O CURRENT S		
	17. NAME OF REFERRING PROVID	CON (Designated by NUC)	17a. 17b	NPI		18. HOSPITALIZATION FROM DD 20. OUTSIDE LAB? YES	BOX 2	O CURRENT S	SERVICES	ility's actu
	17. NAME OF REFERRING PROVID 19. ADDITIONAL CLAIM INFORMAT 21. DIAGNOSIS OR NATURE OF ILL	CON (Designated by NUC)	E 17a. 17b	MM	Ind.	18. HOSPITALIZATION FROM MM DD 20. OUTSIDE LAB?	BOX 2 • Enter th	4 F	nt of the fac	
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