

Sample 1500 Health Insurance Claim Form for Specialized Medical Vehicle Services

Two Trips with Unloaded Mileage and Waiting Time

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A.										3. PATIENT'S BIRTH DATE MM/DD/YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST.										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY ANYTOWN										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
STATE WI										CITY									
ZIP CODE 55555-5555										TELEPHONE (Include Area Code) (XXX XXX-XXXX)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM/DD/YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
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: 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									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER										17a. 1G 654321 17b. NPI _____									
19. RESERVED FOR LOCAL USE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V63.0										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY									
24. A. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
B. PLACE OF SERVICE										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
C. EMG										23. PRIOR AUTHORIZATION NUMBER									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										24. E. DIAGNOSIS POINTER									
F. \$ CHARGES										G. DAYS OR UNITS									
H. EPSC Family Plan										I. ID. QWAL									
J. RENDERING PROVIDER ID. #																			
1 MMDD/YY 11 S0209 U1 TP 1 XXX XX 4.0 NPI																			
2 MMDD/YY 11 A0130 U1 1 XXX XX 1.0 NPI																			
3 MMDD/YY 11 S0209 U1 1 XXX XX 15.0 NPI																			
4 MMDD/YY 11 A0170 U1 1 XXX XX 2.0 NPI																			
5 MMDD/YY 12 S0209 U2 1 XXX XX 20.0 NPI																			
6 _____ NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. 1234JED									
27. ACCEPT ASSIGNMENT? (For great claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ XXXX XX									
29. AMOUNT PAID \$										30. BALANCE DUE \$ XXXX XX									
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.) I.M. PROVIDER MM/DD/YY										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # () I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234									
a. NPI										b. 1D87654321									

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION