

# Sample 1500 Health Insurance Claim Form for Vision Services

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA <span style="float:right">PICA <input type="checkbox"/></span>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A.</b>					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>				
5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						
CITY <b>ANYTOWN</b>			STATE <b>WI</b>		CITY			STATE			
ZIP CODE <b>55555</b>		TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>			ZIP CODE		TELEPHONE (Include Area Code) ( )				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>					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						
a. OTHER INSURED'S POLICY OR GROUP NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER <b>M-8</b>						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						
c. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME						
10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
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 _____						
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			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 24E by Line) 1. <b>365.9</b>					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
2. _____ 3. _____ 4. _____					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 MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		11	92014	1		1	XX XX	1	ZZ	123456789X	
2 MM DD YY		11	92083	1		1	XX XX	1	ZZ	123456789X	
3 MM DD YY		11	92100	1		1	XX XX	1	ZZ	123456789X	
4		NPI	NPI	NPI		NPI	NPI	NPI	NPI	NPI	
5		NPI	NPI	NPI		NPI	NPI	NPI	NPI	NPI	
6		NPI	NPI	NPI		NPI	NPI	NPI	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER		SSN E IN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$			
_____		_____	<b>1234JED</b>		_____	\$ <b>XXX XX</b>	\$ <b>XXXX</b>	\$ <b>XX XX</b>			
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.) <b>I.M. Provider MM/DD/YY</b>			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # <b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>					
SIGNED _____ DATE _____			a. NPI	b.	a. <b>0222222220</b>	b. <b>ZZ123456789X</b>					

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION