

Sample CMS 1500 Claim Form for Physical Therapy Services

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																																							
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <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) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890																																																																																																																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																																																		
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		STATE WI			7. INSURED'S ADDRESS (No., Street)		CITY		STATE																																																																																																														
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()																																																																																																														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO 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 M-7																																																																																																																		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY 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																																																																																																																		
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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE IM Referring MD					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																		
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 436 2. 437.0					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 1234567																																																																																																																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">A DATE(S) OF SERVICE</th> <th rowspan="2">B Place of Service</th> <th rowspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES</th> <th rowspan="2">E DIAGNOSIS CODE</th> <th rowspan="2">F \$ CHARGES</th> <th rowspan="2">G DAYS OR UNITS</th> <th rowspan="2">H EPSDT Family Plan</th> <th rowspan="2">I EMG</th> <th rowspan="2">J COB</th> <th rowspan="2">K RESERVED FOR LOCAL USE</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th>CPT/HCPCS</th> <th>MODIFIER</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>08</td> <td>04</td> <td>05</td> <td>06</td> <td>10</td> <td>11</td> <td>97116 GP</td> <td>1</td> <td>XX XX</td> <td>6.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td>2</td> <td>08</td> <td>20</td> <td>05</td> <td></td> <td></td> <td>11</td> <td>97110 GP</td> <td>2</td> <td>XX XX</td> <td>1.5</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>											A DATE(S) OF SERVICE			B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE	From	To		CPT/HCPCS	MODIFIER	1	08	04	05	06	10	11	97116 GP	1	XX XX	6.0				12345678	2	08	20	05			11	97110 GP	2	XX XX	1.5				12345678	3															4															5															6														
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25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO. 1234JED			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ XX XX		30. BALANCE DUE \$ XX 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>J.M. Authorized</i> MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Therapist 1 W. Williams Anytown, WI 55555 87654321 PIN# GRP#																																																																																																													