

HEALTH INSURANCE CLAIM FORM

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MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <div style="text-align: right; font-weight: bold;">123456789A</div>																																																																																																																																																																																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JOHN J.				3. PATIENT'S BIRTH DATE MM DD YYYY 07 02 1935 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F				4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH, JOHN J.																																																																																																																																																																																													
5. PATIENT'S ADDRESS (No., Street) 1234 FIRST STREET				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 1234 FIRST STREET																																																																																																																																																																																													
CITY ANY CITY		STATE ST		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				CITY ANY CITY		STATE ST																																																																																																																																																																																											
ZIP CODE 99999		TELEPHONE (Include Area Code) (123) 456-7890		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																																																																																																																																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. EMPLOYER'S NAME OR SCHOOL NAME				11. INSURED'S POLICY GROUP OR FECA NUMBER NONE																																																																																																																																																																																													
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.				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 <u>Signature on File</u> DATE <u>01/06/2003</u>																																																																																																																																																																																													
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 <u>Signature on File</u> DATE <u>01/06/2003</u>																																																																																																																																																																																																					
14. DATE OF CURRENT ILLNESS (First Symptom) OR Injury (Accident) OR PREGNANCY (LMP) MM DD YYYY 06 07 2002				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY E11111				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YYYY TO MM DD YYYY 01 06 2003 TO 01 07 2003																																																																																																																																																																																													
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Tom Jones, M.D.				17a. I.D. NUMBER OF REFERRING PHYSICIAN E11111				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YYYY TO MM DD YYYY 01 06 2003 TO 01 07 2003																																																																																																																																																																																													
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0 00				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																																																																																																																																																																																																					
1. <u>721.42</u> 3. _____ 2. _____ 4. _____																																																																																																																																																																																																					
23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A</th> <th colspan="3">B</th> <th colspan="3">C</th> <th colspan="3">D</th> <th colspan="3">E</th> <th colspan="3">F</th> <th colspan="3">G</th> <th colspan="3">H</th> <th colspan="3">I</th> <th colspan="3">J</th> <th colspan="3">K</th> </tr> <tr> <th colspan="3">DATE (S) OF SERVICE</th> <th colspan="3">PLACE OF SERVICE</th> <th colspan="3">TYPE OF SERVICE</th> <th colspan="3">PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="3">DIAGNOSIS CODE</th> <th colspan="3">\$ CHARGES</th> <th colspan="3">DAYS OR UNITS</th> <th colspan="3">EPSDT FAMILY PLAN</th> <th colspan="3">EMG</th> <th colspan="3">COB</th> <th colspan="3">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YYYY</th> <th>MM</th><th>DD</th><th>YYYY</th> <th></th><th></th><th></th> <th></th><th></th><th></th> <th></th><th></th><th></th> <th></th><th></th><th></th> <th>\$</th><th></th><th></th> <th></th><th></th><th></th> <th></th><th></th><th></th> <th></th><th></th><th></th> <th></th><th></th><th></th> <th></th><th></th><th></th> </tr> </thead> <tbody> <tr> <td>01</td><td>06</td><td>2003</td> <td>01</td><td>06</td><td>2003</td> <td>21</td><td></td><td></td> <td>22558</td><td></td><td></td> <td>1</td><td></td><td></td> <td>0</td><td>00</td><td></td> <td>1</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> <td>E11111</td><td></td><td></td> </tr> <tr> <td>01</td><td>06</td><td>2003</td> <td>01</td><td>06</td><td>2003</td> <td>21</td><td></td><td></td> <td>22851</td><td></td><td></td> <td>1</td><td></td><td></td> <td>0</td><td>00</td><td></td> <td>1</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> <td>E11111</td><td></td><td></td> </tr> <tr> <td colspan="12" style="text-align: center;"> <div style="border: 1px solid black; padding: 5px; display: inline-block;"> Application-Intervertebral biomechanical device (cage, bone dowel, etc) </div> </td> </tr> </tbody> </table>												A			B			C			D			E			F			G			H			I			J			K			DATE (S) OF SERVICE			PLACE OF SERVICE			TYPE OF SERVICE			PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE			\$ CHARGES			DAYS OR UNITS			EPSDT FAMILY PLAN			EMG			COB			RESERVED FOR LOCAL USE			MM	DD	YYYY	MM	DD	YYYY													\$																		01	06	2003	01	06	2003	21			22558			1			0	00		1															E11111			01	06	2003	01	06	2003	21			22851			1			0	00		1															E11111			<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Application-Intervertebral biomechanical device (cage, bone dowel, etc) </div>											
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25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN <input type="checkbox"/> EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 181201				27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 0 00		29. AMOUNT PAID \$		30. BALANCE DUE \$																																																																																																																																																																																							
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) SIGNED _____ DATE _____						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) ABC Hospital 5649 Medical Parkway Any City, ST 9999-9999 99-9999999						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Thomas G. Jones, M.D. Physicians Spine Institute Any City, ST 99999-9999 (123) 555-5464 PIN# E11111 GRP# 987654321																																																																																																																																																																																									

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)

The examples provided do not represent the only manner to report the stated procedure. This should only be used as a guideline. Please consult with your advisors to resolve any coding or billing questions that you may have.
 * Incorporates technology developed by Gary K. Michelson, M.D.