

# Sample CMS-1500 Claim Form for Physician Offices and Free-Standing Clinics



**DISCLAIMER:** This is NOT inclusive of all applicable codes that may be reported on a CMS-1500 claim form. Providers should document and code appropriately at all times.

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN (S/N or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S ID. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN, W			3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street) 123 MAIN ST			6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)		
CITY ANYWHERE		STATE CA	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE
ZIP CODE 00001		TELEPHONE (Include Area Code) (000) 555-1234		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ( )		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)		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		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		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 _____		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>			
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		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATE(S) 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. PLACE OF SERVICE CODE 11 for "Office" or 49 for "Independent Clinic"		21. CPT <sup>®1</sup> code 36593 for "Declotting by thrombolytic agent of implanted vascular access device or catheter"		22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER		24. A B C D E F G H I J K DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPS DT Family Plan EMG COB RESERVE D FOR LOCAL USE 1 MM DD YY MM DD YY 11 36593 XX XX X 2 MM DD YY MM DD YY 11 J2997 XX XX 2					
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
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 of office)		33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCA-1500 (U2) (12-90)  
FORM OWCP-1500 FORM RRB-1500



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