

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



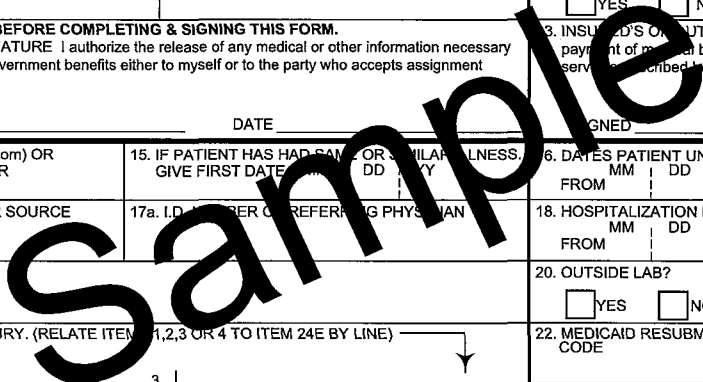
# CMS 1500 also know as HCFA: Universal form used for billing purposes for Health Care Professionals.

CARRIER

HEALTH INSURANCE CLAIM FORM																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input 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"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																								
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT 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)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																								
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 type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																								
11. INSURED'S POLICY GROUP OR FECA NUMBER					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.																								
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)																								
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																								
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																								
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					19. RESERVED FOR LOCAL USE																								
20. OUTSIDE LAB? \$ CHARGES					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM 1, 2, 3 OR 4 TO ITEM 24E BY LINE)																								
22. MEDICAID 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		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE									
From MM DD YY To MM DD YY																													
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2																													
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6																													
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					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.)										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 #									
SIGNED										DATE										PIN#					GRP#				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



**UB04: Uniform institutional provider billing form used by hospitals.**  
**Provides necessary information to process your claim efficiently.**

1										2										3a PAT. CNTRL. #					4 TYPE OF BILL																																																																																														
																				b. MED. REC. #																																																																																																			
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8 PATIENT NAME										9 PATIENT ADDRESS																																																																																																													
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42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE					45 SERV. DATE					46 SERV. UNITS					47 TOTAL CHARGES					48 NON-COVERED CHARGES					49																																																																										
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50 PAYER NAME										51 HEALTH PLAN ID					52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI																																																																																										
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58 INSURED'S NAME										59 P.REL.		60 INSURED'S UNIQUE ID					61 GROUP NAME					62 INSURANCE GROUP NO.																																																																																																	
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63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER					65 EMPLOYER NAME																																																																																																								
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74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		QUAL																																																																																																													
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