Sample of Completed CMS1500
Required

Do Not imprint, or write any information here!! Maryland Medicaid uses this area to imprint the invoice control number (INC). This is vital to processing your claim.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLKLUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): George, Curious

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Complete for Third Party Insurance or Rejection Code!

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 30055555500

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

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 MM DD YY FROM | MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Smiles MD, Sunny

17a. 1D 404555555

17b. NPI 1150252000

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | MM DD YY TO

19. RESERVED FOR LOCAL USE ***DO NOT WRITE ANYTHING HERE!***

Enter the Rendering Provider Number in Block 24 J

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 998 11
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

*Complete for services requiring preauthorization! (DME, DMS etc.)

	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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 10 07		21		49002	U2 51	1	1850 00	1		1D / NPI	404333000 / 1150155500
	N400009737604UN1											
2	12 10 07		21		J1055		1	48 19	1		1D / NPI	404333000 / 1150155500
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES | NO

28. TOTAL CHARGE $ 1898 19

29. AMOUNT PAID $ Third Party Only!

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.)

1/29/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Shock Trauma Center
2 Injury Way
Baltimore, MD 21200

a. 1671234567 b. 1D 340995000

33. BILLING PROVIDER INFO & PH # (410) 555-1234

Shock Trauma Associates, PA
PO Box 1234
Baltimore, MD 21200

a. 1678912345 b. 1D 135580123

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)