
PROVIDER BULLETIN

**REVISED CMS 1500 FORM 02/12
~ Paper CMS 1500 Submissions ~**

The Version 02/12 1500 Health Insurance Claim Form (02/12 1500 Claim Form) has received final approval by the Centers for Medicare & Medicaid Services (CMS) and the Office of Management and Budget (OMB).

The 02/12 Version of the CMS 1500 form is to be used effective April 1, 2014.

The revised form accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

See the attached sample form for your information.

To receive copies of the 02/12 1500 Claim Form, contact:

- Your current forms supplier;
- TFP Data Systems: 1500form@tfpdata.com or 800-482-9367 ext. 58029; or
- The Government Printing Office:
<http://bookstore.gpo.gov/catalog/government-forms-phone-directories> or 866-512-1800

For more information about the new CMS 1500 Form visit

www.nucc.org

If you have any questions, please contact Provider Relations:

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																		
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input type="checkbox"/> (ID#)					OTHER <input type="checkbox"/> (ID#)					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"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
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)																			
CITY					STATE					8. RESERVED FOR NUCC USE					CITY					STATE																								
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																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>																													
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME																													
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																													
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.																													
SIGNED _____										DATE _____										SIGNED _____																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY					15. OTHER DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____															23. PRIOR AUTHORIZATION NUMBER _____																													
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/HCP/CS MODIFIER					E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																							
1																																												
2																																												
3																																												
4																																												
5																																												
6																																												
25. FEDERAL TAX I.D. NUMBER					SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use														
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. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																			
SIGNED _____										DATE _____										a. NPI _____					b. _____					a. NPI _____					b. _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION