Example Form

1500 How to Fill out Form for Reimbursement

Place the Name of your Insurance Provider here)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

Blue Cross of Massachu

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 493L547H29 Blue Cross

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jane Doe

3. PATIENT'S BIRTH DATE MM DD YY: SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 33 Maple Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 33 Maple Lane

CITY: Belmont STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Belmont STATE: MA

ZIP CODE: 02478 TELEPHONE (Include Area Code): (617) 954-6814

ZIP CODE: 02478 TELEPHONE (Include Area Code): (617) 954-6814

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): None

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Blue Cross G549F22

a. OTHER INSURED'S POLICY OR GROUP NUMBER: None

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 1 19 61 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Acme Supplies

c. EMPLOYER'S NAME OR SCHOOL NAME: —

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Preferred

d. INSURANCE PLAN NAME OR PROGRAM NAME: —

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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 Jane Doe DATE 4-6-2010

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 2 9 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 2 9 10

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. William Scott

17a.

17b. NPI 4535674338

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

19. RESERVED FOR LOCAL USE

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. 354.0 carpal Tunnel Syndrome
2. —
3. —
4. —

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 3 10 10				L3923 Right Hand		354.0	84 95			NPI	
2 3 10 10				L3923 Left Hand		354.0	84 95			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 043813636 [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 169 90

29. AMOUNT PAID $ 169 90

30. BALANCE DUE $ 00 0

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. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (800) 798-5210

First Hand Medical
3434 East 7800 South Suite 328
Salt Lake City, Ut. 84121

a. b.

NUCC Instruction Manual available at: www.nucc.org

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

FIRST HAND MED NPI #: 1326273483

HCPCS Code
L3923