Example Claim Form For Medicare

[redacted]

Medicare + Medicaid Claim Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION

MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary from Health Insurance Card
(Last) Doe , (First) John (Middle) G.

SEND COMPLETED FORM TO:
Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

2 Claim Number from Health Insurance Card: 1 2 3 4 5 6 7 8 9 A

Patient's Sex
☒ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
33 Maple Street
(Street or P.O. Box – Include Apartment Number)
Belmont , MA 02478
(City) (State) (Zip)

3b Telephone Number (Include Area Code)
(617) 484-9134

4 Describe the illness or injury for which patient received treatment
Carpal Tunnel Syndrome ICD code: 354.0
Treated with Hand Wrist Orthosis
HCPCS Code: L3908 Prescribed by
Dr. James E. Williams, MD (see prescription attached) supplied by First Hand Medical
NPI #1326273483 EIN# 0438-13636

4b Condition was related to:
A. Patient's employment
☐ Yes ☒ No
B. Accident
☐ Auto ☐ Other No

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☒ No

5 a. Are you employed and covered under an employee health plan?
☐ Yes ☒ No

b. Is your spouse employed and are you covered under your spouse's employee health plan?
☐ Yes ☒ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:

Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name: None

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

6 Signature of Patient (If patient is unable to sign, see Block 6 on reverse)
John A. Doe

6b Date signed
June 3, 2009

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Form CMS-1490S (SC) (01/05) EF 02/2005

Prescription from Dr. Williams and Receipt from First Hand Medical Are Attached