Example of How to Complete Form CMS-1500
The Carpal Solution Hand Finger Orthosis

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER [X] (ID#)

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: 12 15 66 SEX M [ ] F [✔]

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

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

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

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

CITY: Belmont | STATE: MA

8. RESERVED FOR NUCC USE

CITY: Belmont | STATE: MA

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

ZIP CODE: 02478 | TELEPHONE (Include Area Code): (617) 954-6816

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 [✔]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 19 62 SEX M [✔] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [✔]

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

d. INSURANCE PLAN NAME OR PROGRAM NAME: None

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [✔] *If yes*, complete items 9, 9a, and 9d.

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: 5-31-2025

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: None Leave Blank

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 15 2025 QUAL.

15. OTHER DATE QUAL. MM DD YY: 05 15 2025

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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. G56.01 B. G56.02 C. D.
E. F. G. H.
I. J. K. L.

22. 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 05 31 25				L3924	Hand Finger Orthosis R	G56.01	99 95			NPI	
2 05 31 25				L3924	Hand Finger Orthosis L	G56.02	99 95			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 043813636

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 199 90

29. AMOUNT PAID $ 199 90

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

First Hand Medical Tax ID 043813636

4172 S. 650 E, Millcreek, UT 84107

NPI 1326273483 Taxonomy Code: 335E00000X

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD

ENVELOPE BSS-92588-024

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)