CMS-1500 Claim Form Example

OMB-0938-1197

1. Patient and Insured Information

1. Medicare
1a. Insured's ID Number
2. Patientâ€™s Name
3. Patientâ€™s Birth Date
Sex M F
4. Insuredâ€™s Name
5. Patientâ€™s Address
6. Patient Relationship To Insured
7. Insured Address
8. Reserved for NUCC Use
9. Other Insuredâ€™s Name
9a. Other Insuredâ€™s Policy or Group #
9b. Other Insuredâ€™s DOB
Gender

2. Insurance Information

11. Insuredâ€™s Policy Group
11a. Insuredâ€™s Date of Birth
11b. Employerâ€™s Name/School
11c. Insurance Plan Name
12. Patientâ€™s/Authorized Personâ€™s Signature
13. Insuredâ€™s/Authorized Personâ€™s Signature

3. Physician or Supplier Information

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS & Modifier)	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #

4. Other Information

17. Name of Referring Provider or Other Source
17a. Other ID #
17b. NPI #
19. Additional Claim Information
21. Diagnosis or Nature of Illness
22. Resubmission Code
23. Prior Authorization #

5. Billing Provider Info & Signature

25. Federal Tax ID Number
27. Accept Assignment?
31. Signature of Physician or Supplier (Include Degrees or Credentials)
32. Service Facility Location Information
33. Billing Provider Info & PH #