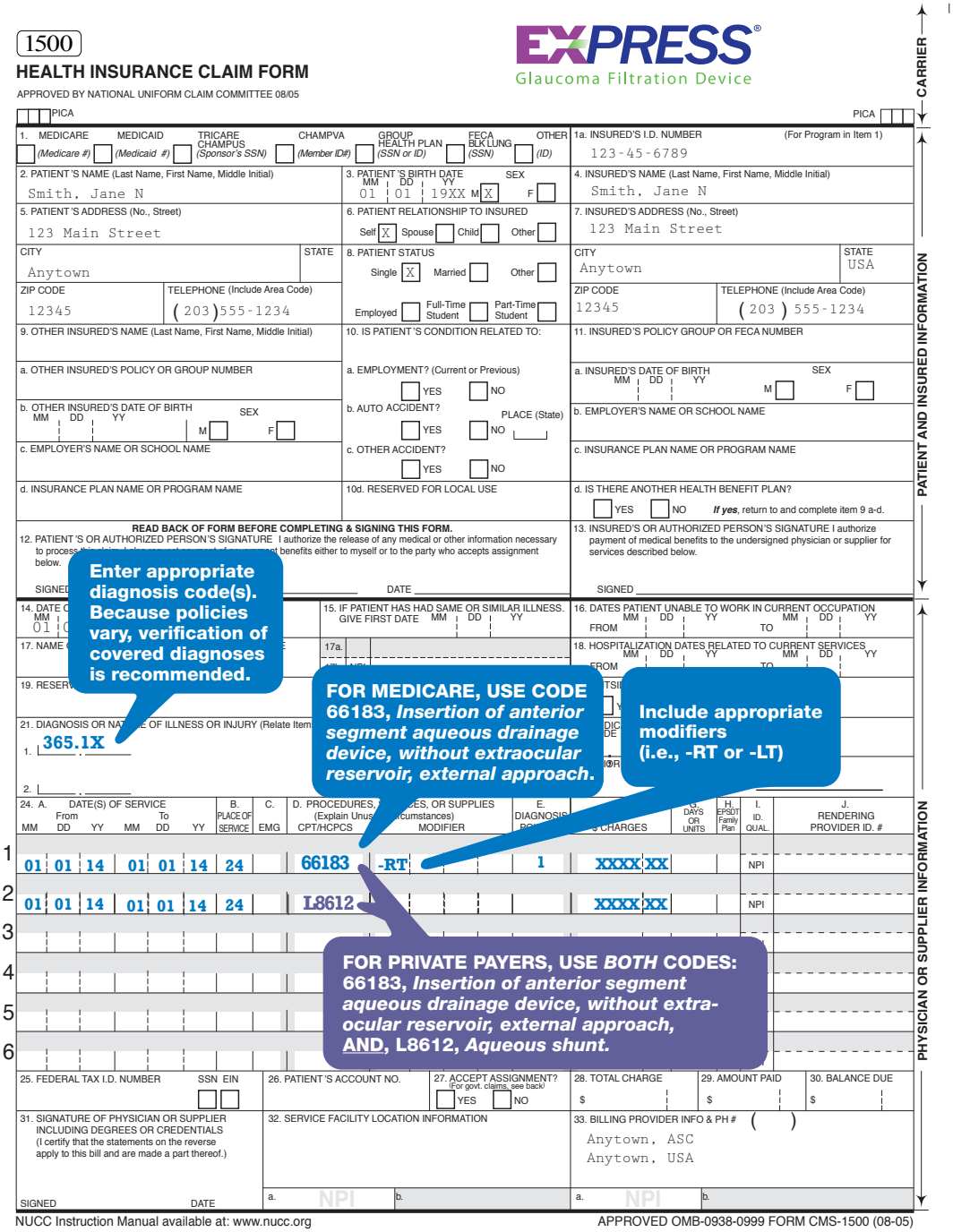
Ambulatory Surgery Center

Sample CMS - 1500 Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

EXPRESS® Glaucoma Filtration Device

PICA

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)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 19XX SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, Jane N

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

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

7. INSURED'S ADDRESS (No., Street): 123 Main Street

CITY: Anytown STATE:

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Anytown STATE: USA

ZIP CODE: 12345 TELEPHONE (Include Area Code): (203)555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 12345 TELEPHONE (Include Area Code): (203) 555-1234

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) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *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 _____ DATE _____

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 _____

14. DATE OF CURRENT: MM DD YY 01 [illegible]

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

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

17. NAME [illegible]

17a.

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

19. RESERV[illegible]

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 365.1X

2.

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	$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 14	01 01 14	24		66183	-RT	1	XXXX XX			NPI	
2 01 01 14	01 01 14	24		L8612			XXXX XX			NPI	
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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 # ( )

Anytown, ASC
Anytown, USA

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Enter appropriate diagnosis code(s). Because policies vary, verification of covered diagnoses is recommended.

FOR MEDICARE, USE CODE 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach.*

Include appropriate modifiers (i.e., -RT or -LT)

FOR PRIVATE PAYERS, USE *BOTH* CODES: 66183, *Insertion of anterior segment aqueous drainage device, without extra-ocular reservoir, external approach,* AND, L8612, *Aqueous shunt.*