The Revised CMS-1500 Form … at a Glance

The Office of Management and Budgets (OMB) has approved a revised CMS-1500 health insurance claim form (version 02/12) to replace the current form (version 08/05). TFP Data Systems, the designated provider of the form, worked directly with the National Uniform Claim Committee (NUCC) on the form's development and distribution.

The revisions, which better align the CMS-1500 with certain changes in the electronic Health Care Claims, are:

1. 1500 symbol replaced with a scannable QR code that takes the user to the NUCC CMS-1500 landing page.
2. **1** – Minor changes to the wording of payer ID number requirements.
3. **8** - Changed to "RESERVED FOR NUCC USE" ("PATIENT STATUS" removed from the form).
4. **9b** and **9c** – Replaced with "RESERVED FOR NUCC USE" ("EMPLOYER'S NAME OR SCHOOL NAME" removed from the form).
5. **10d** – Changed to "CLAIM CODES (Designated by NUCC)."
6. **11b** – Changed to "OTHER CLAIM ID (Designated by NUCC)."
7. **14** – Minor changes to layout of field.
8. **15** – Removed "IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE."
9. **17** – Added a field to report a qualifier to identify which provider is being reported.
10. **21** – Added eight additional lines for diagnosis or nature of illness/injury.
11. **30** – Replaced with "Rsvd for NUCC Use" ("BALANCE DUE" removed from the form).

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY | STATE
8. RESERVED FOR NUCC USE
CITY | STATE
ZIP CODE | TELEPHONE (Include Area Code) ( )
ZIP CODE | TELEPHONE (Include Area Code) ( )
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. 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
d. INSURANCE PLAN NAME OR PROGRAM NAME
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 | 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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
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. B. 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. #

Lines 1–6 (NPI)

PHYSICIAN OR SUPPLIER INFORMATION

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. 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.)
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH # ( )
SIGNED | DATE | a. NPI | b. | a. NPI | b.

NUCC Instruction Manual available at: www.nucc.org | *PLEASE PRINT OR TYPE* | OMB APPROVAL PENDING