



# Sample CMS-1500 Claim Form

**1500**  
**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY STATE ZIP CODE TELEPHONE (Include Area Code)		CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
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.		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 DATE		SIGNED DATE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1. 715.16		23. PRIOR AUTHORIZATION NUMBER	
2. _____		3. _____	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER	
F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Ref I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 01 02 10 01 02 10		J7325 LT	
2 01 02 10 01 02 10		J7325 RT	
3 01 02 10 01 02 10		20610 50	
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (If you're claiming you're based)		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (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		SIGNED DATE	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Enter the appropriate ICD-9-CM code for the patient's diagnosis/condition.

List the unique HCPCS code, J7325, to represent the Synvisc-One or SYNVISC injection.

Enter the CPT procedure code to denote the arthrocentesis, as well as modifier -50 to denote bilateral injection, if applicable.

Enter the appropriate modifier, -LT or -RT, to denote the specific knee injected. This example is for a bilateral procedure.

Enter 48 units to identify Synvisc-One or 16 units to identify SYNVISC.

For demonstration use only. Actual patient coverage will differ on a case-by-case basis.

