

Sample – Not For Official Use

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <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)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code) ()										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										b. EMPLOYER'S NAME OR SCHOOL NAME									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
19. RESERVED FOR LOCAL USE										10d. RESERVED FOR LOCAL USE									
PTNS										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.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized)									
1. _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
2. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
3. _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										23. PRIOR AUTHORIZATION NUMBER									
B. PLACE OF SERVICE										24. F. \$ CHARGES									
C. EMG										G. DAYS OR UNITS									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										H. ESPDT Family Plan									
E. DIAGNOSIS POINTER										I. ID. QUAL.									
64999										J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX I.D. NUMBER										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
SSN EIN										28. TOTAL CHARGE \$									
26. PATIENT'S ACCOUNT NO.										29. AMOUNT PAID \$									
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.)										30. BALANCE DUE \$									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # ()									
a.										b.									

Note: When billing for Percutaneous Tibial Nerve Stimulation (PTNS), please add the following in Box # 19: PTNS

CPT code 64999 – Unlisted procedure, nervous system

Disclaimer: The information contained in this document is provided to help you understand the reimbursement process. It is not intended to increase or maximize reimbursement by any payer. We strongly recommend that providers consult their payer organization with regard to local reimbursement policies. The information contained in this document is provided for information and training purposes only and represents no statement, promise or guarantee by Uroplasty, Inc. concerning levels of reimbursement, payment, or charge. Providers are encouraged to contact their local payers with questions regarding coverage, coding, or payment.