

In July 2006, the Form CMS-1500 (12-90) was revised by the National Uniform Claim Committee (NUCC) predominantly for the purpose of accommodating the National Provider Identifier. Since that time, the industry has been preparing for the implementation of the revised Form CMS-1500 (08-05). In September 2006, Medicare announced that it would implement the revised Form CMS-1500 (08-05) on January 1, 2007 with dual acceptability of both versions until March 31, 2007. Beginning April 1, 2007, the only acceptable version of the form would be the Form CMS-1500 (08-05) and that the prior version, Form CMS-1500 (12-90), would be rejected.

It has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. This resulted in the sale of both printed forms and negatives which do not comply with the form specifications.

Given the circumstances, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. Contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date. However, formal communications in the form of a Change Request and Med Learn Matters article will follow shortly. In addition, during the interim contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to you, we are able to make you aware of the situation which will allow you to begin communications with your form supplier.

The following will help you to properly identify which form is which. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. The best way to identify if your CMS-1500 (08-05) version forms are correct is by looking at the upper right hand corner of the form. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

It is important to note that this issue involves the implementation of the new Form CMS-1500 (08-05) only and does not impact the May 23, 2007 implementation date of the NPI.

Questions may be directed to Brian Reitz at Brian.Reitz@cms.hhs.gov.



Electronic Billing & EDI Transactions

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- [Electronic Data Interchange](#)
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- [Electronic Data Interchange \(EDI\) Support](#)
- [How to Enroll in Medicare Electronic Data Interchange](#)
- [Administrative Simplification Compliance Act Enforcement Reviews](#)
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- [Administrative Simplification Compliance Act Waiver Application](#)
- [Electronic Health Care Claims](#)
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- [Health Care Payment and Remittance Advice](#)
- [Coordination of Benefits](#)
- [Electronic Funds Transfer](#)

Professional paper claim form (CMS-1500)

PLEASE SEE DOWNLOAD BELOW FOR IMPORTANT INFORMATION ABOUT PROBLEM WITH SOME CMS-1500 (08/05) FORMS!

The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional contractors (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies. Please contact your Medicaid State Agency for more details.

The National Uniform Claim Committee (NUCC) is responsible for the maintenance of the CMS-1500 form. CMS does not provide the form to providers for claim submission. In order to purchase claim forms, you should contact the U.S. Government Printing Office at (202) 512-1800, local printing companies in your area, and/or office supply stores. Each of these sources sells the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc).

The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS-1500 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. The majority of paper claims sent to Medicare contractors are scanned using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted by Medicare contractors.

The NUCC revised the CMS-1500 in 2006; the new version, CMS-1500 (08-05), will replace the current CMS-1500 (12-90) version effective April 1, 2007. During the period January 1, 2007 through March 31, 2007, providers that use paper forms for claim submission will be able to submit either the 12-90 version or the 08-05 version of the CMS-1500 form. CMS will discontinue acceptance of 12-90 version of the CMS-1500 form on April 1, 2007.

Electronic Claims Attachments
 Institutional paper claim form (CMS-1450)
Professional paper claim form (CMS-1500)
 Contingency

The CMS-1500 claim form was updated to accommodate the mandated National Provider Identifiers (NPIs). The previous CMS-1500 (12-90) form did not have the fields for reporting of NPIs. Further information on the CMS-1500 form is available through the NUCC web site. A link is provided below.

CMS has received Office and Management and Budget approval for the CMS-1500 (08-05), as required under the Paperwork Reduction Act. You can find Medicare CMS-1500 completion and coding instructions, as well as the print specifications in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04).

Downloads

[BREAKING NEWS! CMS-1500 \(08/05\)](#)
[Invalid 1500 Form FAQs \[PDF, 45KB\]](#)

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CMS-1500 (08/05) Invalid Paper Form Frequently Asked Questions (FAQs)

Q 1) I received an email that said that some invalid CMS-1500 (08/05) forms were printed which may reject if submitted to Medicare. I didn't see any information on the CMS website about this on March 9th when I received the email. Can you confirm that the email came from CMS and is correct?

A 1) Yes, it was sent by CMS and it is correct. Due to the approaching April 1 deadline for rejection of CMS-1500 (12/90) forms, we wanted to get information to physicians, practitioners and suppliers who might be affected by this problem as quickly as possible. A provider list serve is maintained by the Provider Outreach Group in CMS. We used that list serve to send the March 9th email as that was the fastest way to spread the message. Since March 9, we have also posted information on the CMS web site (www.cms.hhs.gov; click on the CMS-1500 listing in the highlight box on the opening page of the Web site to obtain this information), are in the process of publishing a One Time Notice (OTN) that will be available in Publication 100-20; and have discussed this with the Medicare contractors, the Government Printing Office, the National Uniform Claims Committee (NUCC) and the company engaged by the NUCC to produce the printing specifications for the new form. We are trying to resolve the problem, and determine its scope as well as spread the information to as many CMS-1500 users as possible. A Med Learn Matters article will be issued very soon, following final clearance of the OTN.

Q 2) What is the actual problem?

A 2) There appear to be a couple of problems. Some entities printed CMS-1500 forms using the example posted in the forms section of the CMS Web site. That form was not intended for use in this way as it does not contain the "drop out" ink colors that are needed to enable the data on claims submitted with those copies to be read by the optical character recognition (OCR) equipment used for entry of most paper claims to the Medicare adjudication system. That form is also not to scale. The second problem which was mentioned in the March 9th email involves misalignment of the printed forms. In most cases, it appears that the "crop marks" create a top margin that is too short and a bottom margin that is too long. As result, when the forms are fed into certain types of OCR equipment, the claim data is not located in the precise location where that equipment is programmed to look for that data, resulting in rejection of those paper claims as the OCR equipment concludes that required data elements are missing.

Q 3) Do the problems apply to all insurers or just to Medicare?

A 3) To the extent other insurers accept the CMS-1500 (08/05) form, these problems could also be experienced by those other insurers. We can only address the problems as they apply to Medicare though. If other insurers experience these problems, they will need to notify submitters of the misprinted forms themselves.

Q 4) What are physicians, practitioners, suppliers and billing agents who have had their paper claims rejected by a Medicare contractor because they were submitted on invalid CMS-1500 (08/05) forms supposed to do so they can be paid?

A 4) They need to contact the organization, person, store or printer from whom they obtained their paper forms to let them know that Medicare considers their forms to be invalid and to ask what provisions will be made for replacement of the invalid forms with valid forms. In the event the seller is not aware that their forms are invalid, it may take that seller some time to print enough paper forms to replace the invalid stock that was sold. That seller should at least stop selling any invalid forms that may still be in their inventory. The claim submitters can use the CMS-1500 (12/90) stock and software to resubmit those claims if still able to produce paper claims in that version and the submitters prefer not to wait until replacement forms are available. Medicare will not begin to reject those forms beginning April 1, 2007 as originally planned. We expect to continue to accept those forms until at least June 1, while we take action

to get misprinted forms off the market and to have them replaced by valid forms. Medicare will continue to accept paper claims using the 12/90 version of the CMS-1500 without NPIs. We will provide advanced notice to the health care industry of the new termination date for the 12/90 version CMS-1500 once the problem is resolved.

Q 5) How does this affect the NPI implementation date of May 23, 2007.

A 5) This issue applies only to certain CMS-1500 paper forms and does not involve the institutional paper claims form (CMS-1450/UB-04) or the electronic claim formats adopted as national standards under HIPAA. More than 99 percent of the institutional claims and more than 92 percent of the professional claims sent Medicare are transmitted electronically using a HIPAA adopted format. Although Medicare has elected to require NPIs on paper claims as well as on electronic claims, the HIPAA NPI regulation does not require use of NPIs on paper claim forms. As result, CMS has more discretion concerning whether and when to require NPIs on paper claims. This CMS-1500 (08/05) issue will not result in delay of the date by which NPIs must replace provider legacy identifiers on valid CMS-1500 (08/05) forms or on UB-04, X12 837 version 4010A1 or NCPDP HIPAA version claims.

Q 6) Where do I place the NPI on the old 1500 form?

A 6) The old form does not have fields for reporting of NPIs. As result, those individuals who continue to use the 12/90 version of the CMS-1500 will not be required to report NPIs on the claims they submit using the old form.

Q 7) Is the June 1, 2007 date firm or simply a target?

A 7) It is currently a "target" date. Once a final decision has been made, the actual date will be communicated.

Q 8) Can you direct me to a print vendor where I can purchase valid CMS-1500 (08/05) forms?

A 8) CMS does not license or collect information on those printers that produce copies of the paper claim forms. As result, we cannot advise which printers or vendors have valid copies of the CMS-1500 (08/05) and which do not. There is nothing on the invalid forms that rejected to date that identifies the printer(s) of those forms. As result, we must rely on those providers, whose paper claims have been rejected by a Medicare contractor as invalid, to advise the entity from which they purchased their forms that they are invalid. The Government Printing Office (GPO) does sell printed forms as well as negatives of the form for use by printers. GPO stopped selling the forms as soon as the misalignment problem was detected. GPO is in the process of replacing their stock with valid forms but we do not yet know when the valid forms will be available for sale by the GPO.

Q 9) The 1500 form is no longer posted to the CMS forms Web site. When will it be posted again?

A 9) We are working to have a corrected form posted there, but this form cannot be used for submission of CMS-1500 (08/05) claims. It is posted at that site so providers can see what the new form looks like. The form on the CMS Web page is not to scale and is not printed in the "drop out" ink color required to enable those claims to be read by OCR equipment. No provider or printer should ever produce that form using the copy on the CMS Web page. This same principal applied to the CMS-1500 (12/90) version of the form.

Q 10) I purchased forms and they appear correct. Can you tell by looking at a 08/05 version of the form if it is not valid?

A 10) The specific formatting issue we have seen involves top and bottom margins only, but the problem may not be limited to only the top and bottom margins. The best way to identify these is by looking at the upper right hand corner of a form. If the tip of the red arrow above the vertically stacked word "CARRIER" is touching or close to touching the top edge of the form, then the form is not printed to specifications. There should be approximately one quarter of one inch between the tip of the arrow and the top edge of the paper on a properly formatted form.

Q 11) Our 08/05 version forms are valid; can we use them now or should we wait?

A 11) If your forms are valid, insofar as they have not been rejected by any Medicare contractor, you should continue to submit claims using those copies of the form.

Q 12) I generally bill electronically but I have not been able to obtain NPIs for each of the providers identified on my claims, such as a supervising physician or a purchased services provider. Since you will not begin to reject CMS-1500 (12/90) version forms that lack NPIs effective May 23, 2007, can I use that form to submit claims to Medicare when I do not know the NPI of one or more providers involved with a patient's care?

A 12) The Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, except in very limited situations, such as when a practice that submits CMS-1500 forms has fewer than 10 full-time equivalent employees. If the submitter of a paper form has been reviewed by Medicare and it was determined the provider does not qualify for an exception from the ASCA requirement, any paper claims submitted by or for that provider will be denied. No provider that does not meet ASCA exception criteria may submit paper claims, even if they do not know the NPI of one or more providers that must be identified on a claim sent to Medicare. Information on ASCA, the exception criteria and ASCA reviews can be viewed at www.cms.hhs.gov/manuals by clicking on Internet Only Manuals, selecting Publication 100-04 on the next page and then scrolling to chapter 24. The ASCA information is in sections 90-90.6 of that chapter.

NEW CMS-1500

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LGNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN)</small>		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 <input type="text"/> / <input type="text"/> / <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. OTHER INSURED'S DATE OF BIRTH <input type="text"/> / <input type="text"/> / <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F c. EMPLOYER'S NAME OR SCHOOL NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH <input type="text"/> / <input type="text"/> / <input type="text"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		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 _____	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medicare 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 _____			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) <input type="text"/> / <input type="text"/> / <input type="text"/>		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE <input type="text"/> / <input type="text"/> / <input type="text"/>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <input type="text"/> / <input type="text"/> / <input type="text"/> TO <input type="text"/> / <input type="text"/> / <input type="text"/> 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <input type="text"/> / <input type="text"/> / <input type="text"/> TO <input type="text"/> / <input type="text"/> / <input type="text"/>	
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) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____	
24. A. DATE(S) OF SERVICE From <input type="text"/> / <input type="text"/> / <input type="text"/> To <input type="text"/> / <input type="text"/> / <input type="text"/> B. PLACE OF SERVICE _____ C. EMG _____ D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) _____ E. DIAGNOSIS POINTER _____ F. \$ CHARGES _____ G. DAYS OR UNITS _____ H. PERSON (Family) Fee _____ I. ID. QUAL _____ J. RENDERING PROVIDER ID. # _____			
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. _____	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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. _____ b. _____	
		33. BILLING PROVIDER INFO & PH # () a. _____ b. _____	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

NEW CMS-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysician's must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5526). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1362, 1372 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (5), and 44 USC 3161, 41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 8101 et seq, and 80 USC 901 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37548, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-6, ESA-8, ESA-12, ESA-19, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 9801-9812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

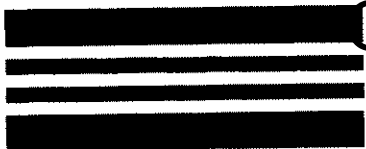
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0998. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PSA Reports Clearance Office, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

PLEASE
DO NOT
STAPLE
IN THIS
AREA



OLD CMS-1500

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <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 M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) CITY STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <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	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
1. _____ 2. _____ 3. _____ 4. _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		23. PRIOR AUTHORIZATION NUMBER	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

OLD CMS 1500

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.