

Locator #	Description	Instructions	Alerts
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Leave blank.	
17a	Unlabelled	Situational – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is required to be entered.	The PCP's 7-digit referral authorization number must be entered in block 17a.
17b	NPI	Optional.	The revised form accommodates the entry of the referring provider's NPI. Enter the CommunityCARE PCP's NPI.

Locator #	Description	Instructions	Alerts
33b	Unlabelled	Required – Enter the billing provider’s 7-digit Medicaid ID number.	Formerly entered in Block 9 of the Unisys 105 Claim Form. The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

SAMPLE AMBULANCE CLAIM FORM

1500

AMB

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567891234					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Adalam, Mary						3. PATIENT'S BIRTH DATE MM DD YY 06 11 89			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
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)						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL carrier code if applicable						a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME		
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 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				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. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		
1. 458.9						3. _____			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		
2. _____						4. _____			23. PRIOR AUTHORIZATION NUMBER 987654321		
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. DENTS UNITS	H. SPORT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID #
1. 04 16 09 04 16 09		9	A0431	SH		6100.00	1	NPI	_____	_____	
2. 04 16 09 04 16 09		9	A0436	SH		2688.00	32	NPI	_____	_____	
3. 04 16 09 04 16 09		9	A0398	SH		109.00	1	NPI	_____	_____	
4. 04 16 09 04 16 09		9	A0394	SH		108.00	1	NPI	_____	_____	
5. 04 16 09 04 16 09		9	A0422	SH		99.00	1	NPI	_____	_____	
6. _____		_____	_____	_____		_____	_____	NPI	_____	_____	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO. 12345			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 9104.00	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.) Ima Biller 5/1/09			32. SERVICE FACILITY LOCATION INFORMATION 123 Any Street 9:00 a.m. Anywhere, LA 321 Nowhere Rd. Anywhere, LA 9:30 a.m.			33. BILLING PROVIDER INFO & PH # (264) 555-0000 ABC Ambulance Service 123 Smiley St. Sunny, LA 70000					
SIGNED _____ DATE _____			a. NPI _____ b. _____			a. 1357901357	b. 1999999	_____	_____	_____	

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