

HCP Office Form: Information

The sample claim form below is for reference only.

Information provided in this resource is for informational purposes only and does not guarantee that codes will be appropriate or that coverage and reimbursement will result. Customers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. This resource is not intended to be legal advice or substitute for a provider's independent judgment.

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

1. MEDICARE MEDICAID TRI CARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare#) (Medicaid#) (ID#/DoDt) (Member ID#) (ID#) (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 CITY STATE

8. RESERVED FOR NUCC USE

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

b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? YES NO PLACE (State)

c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES NO

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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical of 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM | DD | YY QUAL |

15. OTHER 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. NPI 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		B. PLACE OF SERVICE	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. H. DAYS OR UNITS	I. L. ID. QUAL	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY							
1									
2									
3									
4									
5									
6									

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. Revd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OF 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. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Box 19
Product name, route of administration, NDC, dosage (guidelines will vary by payer)

Box 21
Applicable diagnosis codes

Box 24D
Approved product and administrator coding
Until permanent J-code is approved for SUNLENCA, use miscellaneous code here.

Box 24E
Record ICD-10 code from Box 21

Box 24G
Appropriate units used
• On a separate line, enter units of waste (if applicable) and any associated modifier (indicate unit to mg conversion for SUNLENCA[®] [lenacapavir] injection 463.5 mg/1.5 mL)

Advancing Access cannot submit information or paperwork to the patient's insurance company on behalf of your office.