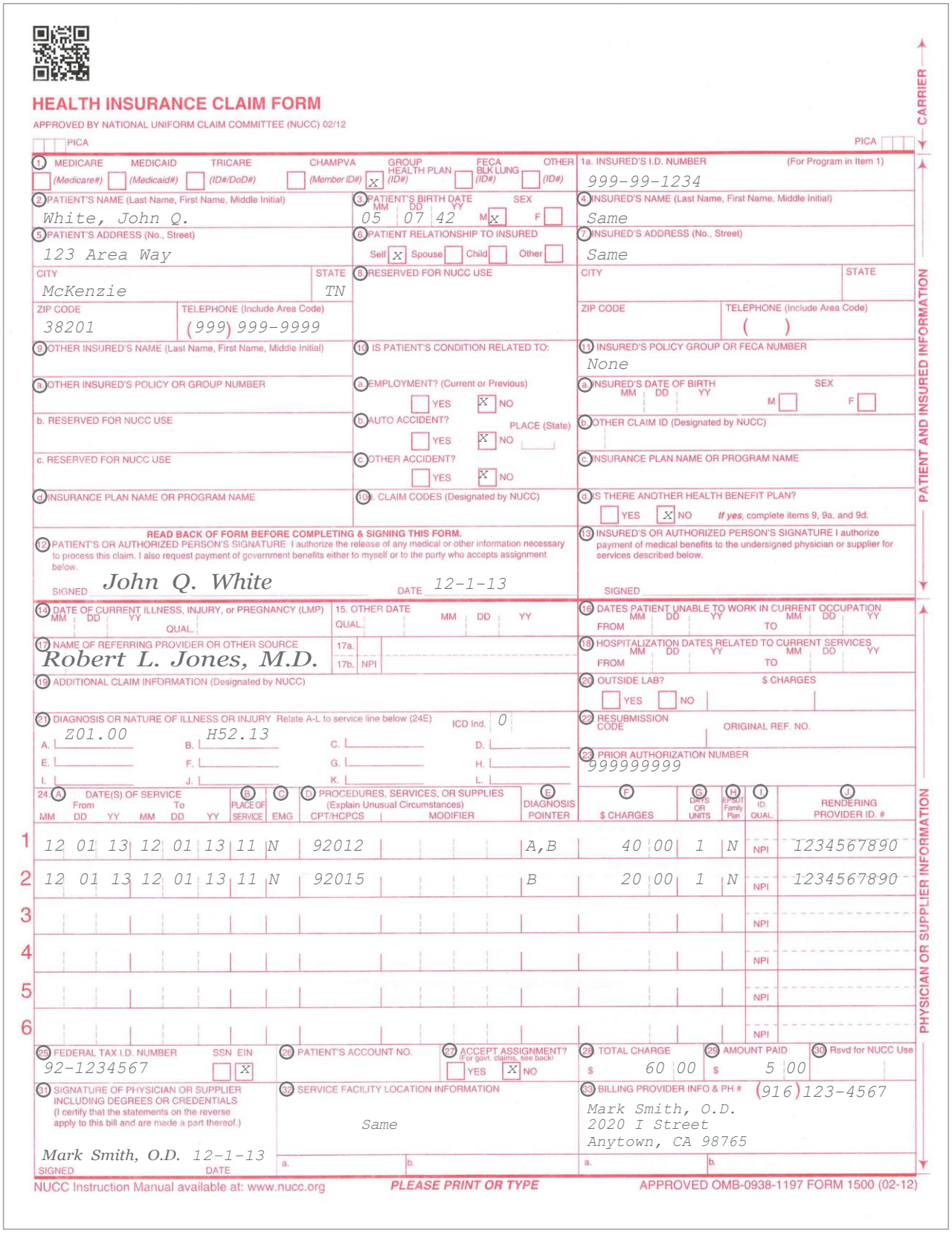
CMS-1500 Claim Form
Quick Reference Card

vsp vision care



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHchampVA (Member ID#) / GROUP HEALTH PLAN (ID#) [X] / FECA BLK LUNG (ID#) / OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999-99-1234
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): White, John Q.	3. PATIENT'S BIRTH DATE MM DD YY: 05 07 42 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same	
5. PATIENT'S ADDRESS (No., Street): 123 Area Way	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): Same	
CITY: McKenzie STATE: TN	8. RESERVED FOR NUCC USE
CITY STATE	
ZIP CODE: 38201 TELEPHONE (Include Area Code): (999) 999-9999	
ZIP CODE TELEPHONE (Include Area Code): ( )	
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: None	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

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: John Q. White DATE: 12-1-13

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Robert L. Jones, M.D.	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. 0 A. Z01.00 B. H52.13 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 999999999

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 DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1	12 01 13	12 01 13	11	N	92012		A,B	40 00	1	N	NPI 1234567890
2	12 01 13	12 01 13	11	N	92015		B	20 00	1	N	NPI 1234567890
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: 92-1234567 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 60 00	29. AMOUNT PAID $ 5 00	30. Rsvd for NUCC Use
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.) Mark Smith, O.D. 12-1-13 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION Same a. b.		33. BILLING PROVIDER INFO & PH #: (916) 123-4567 Mark Smith, O.D. 2020 I Street Anytown, CA 98765 a. b.		

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Completing the CMS-1500 Form

1 Check the box(es) that identifies the type of health insurance coverage(s) applicable.

1a Enter insured's ID number.

2 Enter patient's full name.

3 Enter patient's birthdate (e.g., 05/07/42) and gender.

4 Enter insured's full name (indicate "Same" if the insured is the patient).

5 Enter patient's complete current address and telephone number.

6 Indicate the patient's relationship to the insured.

7 Enter the insured's address (indicate "Same" if same as patient's).

8 Reserved for NUCC.

9 If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the insured's name, then complete 9a and 9d.

10a Check Yes if any of the services described in Box 24 relate to an employment-related accident.

10b Check Yes if any of the services described in Box 24 relate to an auto accident. If Yes, indicate the state where the accident occurred.

10c Check Yes if the services described in Box 24 relate to any other type of accident.

10d Reserved for NUCC.

11 If there is no other eyecare coverage primary to VSP,® enter "None." This box is required to verify that the provider has made a good-faith effort to determine whether VSP is the primary carrier, then complete 11a, 11c, and 11d.

11d Check Yes or No to indicate whether there is another health benefit plan for eyecare. If Yes, complete 9, 9a, and 9d.

12 The patient or authorized representative is required to sign and date this field unless the signature is on file. If the signature is on file, enter "SOF."

13 The signature in this field authorizes payment of benefits to the provider.

14 If you checked Yes in Box 10a, b or c, enter the date of injury. No qualifier needed.

15 If patient has had the same or similar illness, enter the date of previous onset. No qualifier needed.

16 Enter the dates the patient is unable to work in current occupation. An entry in this field may indicate employment-related insurance coverage.

17 Enter the full name of the referring provider, if applicable.

17a This field is not required—leave blank.

17b Enter the referring/ordering provider's 10 digit NPI number.

18 Enter hospitalization dates for current condition, if applicable.

19 For VSP claims, this box requires the following information as applicable: For routine eyecare services, indicate "Share of Cost (SOC)" or "Foster Care" and complete Box 29. Indicate "two pairs of glasses in lieu of bifocals." If you need to indicate multiple items in this box, separate items with a semicolon (e.g., "Share of Cost; two pairs of glasses in lieu of bifocals").

20 This field is not required—leave blank.

21 **Indicate ICD code set.** Enter: **0** for ICD-10 In ICD Ind box. **Enter the patient's diagnosis/condition.** All physician specialties are required to use ICD codes and code to the highest level of specificity. Enter codes in priority order (primary, secondary, etc). Primary diagnosis codes should be patient's chief complaint.

22 If this is a resubmission of an unprocessable or denied claim, enter original claim number in Original Ref. No. box.

23 Enter all applicable VSP authorization numbers.

24A Enter the month, day and year for each procedure, service or supply.

24B Enter the appropriate place of service code, as provided by the health insurance entity checked in Box 1. Indicate a place of service code for each item used or service performed.

24C Enter Y (Yes) or N (No) to indicate whether you provided emergency treatment.

24D Identify the procedure, service or supply with the appropriate CPT/HCPCS code and up to four modifiers*.

24E Enter the one-digit line letter which refers to the primary diagnosis from field 21 for each service billed.

24F Enter your usual and customary billed charge for each service.

24G Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies or lenses. If only one service is performed, enter the number 1.

24H Enter Y (Yes) or N (No) to indicate whether the patient was referred for further exam due to an Early Periodic Screening Diagnostic Test (EPSDT).

24I This field is not required—leave as is.

24J Enter the NPI of the rendering provider in the lower portion of the field.

25 Enter the federal tax ID of the provider/practice receiving payment, and check whether it is an SSN or EIN.

26 Enter the patient account number assigned by the provider's accounting system. This box is optional and is used to help you with patient identification.

27 Check Yes or No to indicate whether reimbursement for this claim will be accepted as payment in full.

28 Enter total charges for the services (total of all charges in Column 24F).

29 Enter the amount paid by the patient and/or other insurance, if applicable, for the charges represented in Box 28 (i.e., copayment and/or overages). For patients identified as participating in a flexible spending account on the VSP Patient Record Report, enter the total amount paid by the patient including any non-covered services.

30 Reserved for NUCC.

31 Enter signature of provider or representative and the date the form was signed. A stamped or computer-generated signature is acceptable.

32 & 32A Enter the name, physical address, and NPI of the office or facility where services were provided, only if it differs from Box 33 or if Box 33 is a P.O. Box. Indicate "Same" if same address as Box 33-do not leave blank.

33 & 33A Enter the name, billing address, ZIP code, telephone number, and NPI of the billing provider or group. This is a required field.

***Multiple page claims—**When reporting line item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim.

Ordering More Forms - CMS-1500 forms may be obtained from:

American Medical Association Insurance Forms
c/o American Medical Association Order Dept.
(800) 621-8335

Vision West Incorporated
CA (800) 640-9485
US (800) 235-6999

American Optometric Association
(314) 991-4100