

The Revised CMS-1500 Form ... at a Glance

The Office of Management and Budgets (OMB) has approved a revised CMS-1500 health insurance claim form (version 02/12) to replace the current form (version 08/05). TFP Data Systems, the designated provider of the form, worked directly with the National Uniform Claim Committee (NUCC) on the form's development and distribution.

The revisions, which better align the CMS-1500 with certain changes in the electronic Health Care Claims, are:

<p>1 1500 symbol replaced with a scannable QR code that takes the user to the NUCC CMS-1500 landing page.</p> <p>2 1 – Minor changes to the wording of payer ID number requirements.</p> <p>3 8 - Changed to "RESERVED FOR NUCC USE" ("PATIENT STATUS" removed from the form).</p> <p>4 9b and 9c – Replaced with "RESERVED FOR NUCC USE" ("EMPLOYER'S NAME OR SCHOOL NAME" removed from the form).</p> <p>5 10d – Changed to "CLAIM CODES (Designated by NUCC)."</p> <p>6 11b – Changed to "OTHER CLAIM ID (Designated by NUCC)."</p> <p>7 14 – Minor changes to layout of field.</p> <p>8 15 – Removed "IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE."</p> <p>9 17 – Added a field to report a qualifier to identify which provider is being reported.</p> <p>10 21 – Added eight additional lines for diagnosis or nature of illness/injury.</p> <p>11 30 – Replaced with "Rsvd for NUCC Use" ("BALANCE DUE" removed from the form).</p>	<p>HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12</p> <p>1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BENEFIT OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)</p> <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p>3. PATIENT'S BIRTH DATE MM DD YY SEX M F</p> <p>4. INSURED'S I.D. NUMBER (For Program in Item 1)</p> <p>5. PATIENT'S ADDRESS (No., Street)</p> <p>6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other</p> <p>7. INSURED'S ADDRESS (No., Street)</p> <p>8. RESERVED FOR NUCC USE</p> <p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>10. IS PATIENT'S CONDITION RELATED TO:</p> <p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p> <p>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.</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL.</p> <p>15. OTHER DATE MM DD YY QUAL.</p> <p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI</p> <p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</p> <p>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p> <p>20. OUTSIDE LAB? \$ CHARGES YES NO</p> <p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.</p> <p>22. RESUBMISSION CODE ORIGINAL REF. NO.</p> <p>23. PRIOR AUTHORIZATION NUMBER</p> <p>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. \$ G. DATES OF UNITS H. ICD-9 (Family Plan) I. ID. QUAL. J. RENDERING PROVIDER ID. #</p> <p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p> <p>26. PATIENT'S ACCOUNT NO.</p> <p>27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO</p> <p>28. TOTAL CHARGE \$</p> <p>29. AMOUNT PAID \$</p> <p>30. Rsvd for NUCC Use</p> <p>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.)</p> <p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>33. BILLING PROVIDER INFO & PH # ()</p> <p>SIGNED DATE a. NPI b. NPI</p> <p>NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE OMB APPROVAL PENDING</p>
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File Claims with Complete Confidence

The TFP-supported CMS-1500 offers some distinct advantages for healthcare customers. It is 100% compliant and printed to exact specifications. It also uses soy-based OCR "dropout" red ink and SFI (Sustainable Forestry Initiative) 20# paper for greater scanning accuracy. As a result, we're so confident of our CMS-1500 form's acceptance by insurance carriers that we offer **Anti-Rejection Protection™***

Our forms are fully compliant and rejection-proof to ensure quicker payment by insurance companies.

Please be aware that the revised form is available for testing and preparation purposes only, and should not be used for official claims submission at this time.

*If a CMS-1500 form manufactured by TFP is rejected by an insurance carrier due to improper formatting or print quality, TFP will provide a full replacement order of the purchaser's forms. To qualify, the purchaser must notify his/her forms provider no later than 20 days after the rejection letter is issued. Upon review of the rejection letter and confirmation that the rejected forms were manufactured by TFP, TFP will send a full replacement order of the affected items. This Anti-Rejection Protection™ limited warranty applies to rejections based on the form itself being invalid due to ink quality or formatting, such as data elements being improperly positioned or misaligned. This protection does not apply to missing or incorrect entries provided by the user.

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