CMS-1500 Claim Form (Training Version for Workers’ Compensation)

This version is for internal training and educational purposes only. Do not submit this form to payers.

## Section 1: Insurance Information

1. Type of Insurance: Check 'Other' for Workers' Compensation.

1a. Insured’s ID Number: Enter the WC claim number.

## Section 2: Patient Information

2. Patient’s Name: Full name as on file with the employer/insurer.

3. Patient’s Birth Date & Sex

5. Patient’s Address

6. Patient Relationship to Insured: 'Self'

7. Insured’s Address: Leave blank or use employer info if required.

## Section 3: Billing Information

9. Other Insured’s Name: Leave blank for WC cases.

11. Insured’s Policy or Group Number: Enter WC claim number again.

11c. Insurance Plan Name: Workers’ Compensation Carrier

## Section 4: Medical Information

21. Diagnosis or Nature of Illness/Injury: Use ICD-10 codes.

24. Services Provided:

- Date(s) of service

- CPT/HCPCS codes with modifiers

- Units, charges, diagnosis pointer

## Section 5: Provider Information

25. Federal Tax ID Number

26. Patient Account Number (internal use)

27. Accept Assignment: Check ‘Yes’

28. Total Charge

31. Signature of Physician or Supplier

33. Billing Provider Info & Phone Number