

MASTERING THE CMS 1500 CLAIM FORM

HEALTH INSURANCE CLAIM FORM

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

PICA ☐ ☐ ☐ ☐										PICA ☐ ☐ ☐ ☐									
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA (WORKING) ☐ OTHER ☐ (Medicare) (Medicaid) (DMEPOS) (Number ID#) (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									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code)										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? ☐ YES ☐ NO									
g. INSURANCE PLAN NAME OR PROGRAM NAME										10a. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED DATE										a. INSURED'S DATE OF BIRTH MM / DD / YY SEX ☐ M ☐ F									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM / DD / YY) QUAL										b. OTHER CLAIM ID (Designated by NUCC)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete Items 9, 9a, and 9d.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to service line below Q-Z)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
A L B L C L D L E L F L G L H L I L J L K L L L										SIGNED									
24. A. DATE(S) OF SERVICE From MM / DD / YY To MM / DD / YY B. PLACE OF SERVICE C. EMS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DEDUCTIBLE H. COINSURANCE I. CO-PAID J. RENDERING PROVIDER ID #										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM / DD / YY TO MM / DD / YY									
1. 2. 3. 4. 5. 6.										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM / DD / YY TO MM / DD / YY									
25. FEDERAL TAX I.D. NUMBER SSN EIN										20. OUTSIDE LAB? \$ CHARGES ☐ YES ☐ NO									
26. PATIENT'S ACCOUNT NO.										22. REASSIGNMENT CODE ORIGINAL REF. NO.									
27. ACCEPT ASSIGNMENT? YES ☐ NO ☐										23. PRIOR AUTHORIZATION NUMBER									
28. TOTAL CHARGE \$										29. AMOUNT PAID \$									
30. BILLING PROVIDER INFO & PH # ()										30. Paid by NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED DATE										a. NPI b. NPI									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0936-1197 FORM 1500 (02-12)

LEARNING OBJECTIVES

- HISTORY & PURPOSE OF THE CMS 1500 CLAIM FORM
- TYPES OF MEDICAL INSURANCE CLAIM FORMS
- COMMON ERRORS THAT CAUSE REJECTIONS AND DENIALS
- PRO TIPS FOR PROPER COMPLETION OF THE CLAIM FORM
- INTERACTIVE STEP BY STEP CLAIM FORM TUTORIAL
- KNOWLEDGE CHECK (5 QUESTIONS)
- AAPC CPB EXAM CASE STUDY PRACTICE QUESTION

CMS-1500 CLAIM FORM

- Formerly called: HCFA 1500 (Health Care Financing Administration).
- Standard paper claim form used to bill Medicare, Medicaid, Commercial Payers, Auto No Fault, Workers' Compensation.
- Developed and maintained by NUCC (National Uniform Claim Committee).
- Revised in 2012 to accommodate ICD-10-CM and 5010 standards.
- Current version: 02/12
- Includes items; 1-33b

The image shows the CMS-1500 Health Insurance Claim Form, a standard paper form used for billing health insurance. The form is divided into several sections, each with specific fields for data entry. At the top left, there is a QR code and the title 'HEALTH INSURANCE CLAIM FORM'. Below this, it states 'APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12'. The form is organized into columns and rows, with various checkboxes and text boxes for different types of insurance (Medicare, Medicaid, etc.) and patient information (name, birth date, address, etc.). The bottom section includes fields for the provider's signature, date, and NPI (National Provider Identifier). The form is labeled 'CMS-1500' and '02/12'.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under 18 U.S.C. 1001 and may be subject to civil penalties.

UB-04 CLAIM FORM

- Also called: CMS-1450
- Formerly called: UB-92, UB-82
- Standard paper claim form used to bill institutional services (hospital, skilled nursing facility, rehab center, hospice and certain home health services)
- Developed and maintained by NUBC (National Uniform Billing Committee).
- UB-82 introduced in 1982, Replaced by the UB-92 in 1993, Revised in 2007 to UB-04 to support the NPI, compliance with HIPAA transaction standards, and expanded diagnosis codes for ICD-10-CM.
- Current version: UB-04
- Includes form locator fields; FL1-FL81

1		2		3a PAT CNTL # b. MED REG #		4 TYPE OF BILL	
5 FED TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH			
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE				11 SEX			
12 DATE				13 ADMISSION DATE			
14 TYPE				15 SRC			
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CMS-1500 vs. UB-04 Claim Form: Key Differences

Feature	CMS-1500	UB-04/CMS-1450
Used For	Professional outpatient services (e.g., physician offices, clinics)	Institutional services (e.g., hospitals, skilled nursing facilities, rehab centers, hospice, certain home health services)
Developed By	NUCC (National Uniform Claim Committee)	NUBC (National Uniform Billing Committee)
Paper Form Version	02/12 (formerly HCFA 1500)	UB-04 (formerly UB-92, UB-82)
Payer Types	Medicare Part B, Medicaid, commercial insurance, Workers' Comp, Auto No Fault	Medicare Part A, Medicaid, commercial insurance, Workers' Comp, Auto No Fault
Form Field Names	Items 1-33	Form Locators FL1-FL81
Coding Used	CPT/HCPCS + ICD-10-CM	Revenue Codes, CPT/HCPCS, ICD-10-PCS, ICD-10-CM
Claim Type	Individual provider-based claim	Facility or institutional claim
Submission Method	Paper or electronic (837P)	Paper or electronic (837I)

12 Pro Tips for Claim Form Completion

- Double-Check Patient Demographics
- Use Current, Valid Codes
- Verify Insurance Eligibility Before Submitting
- Complete All Required Fields Accurately
- Include the Correct Provider and Facility Identifiers
- Match Diagnosis to Procedure Code Appropriately
- Use Correct Place of Service (POS) Codes
- Use Modifiers Correctly and Only When Necessary
- Attach All Required Documentation
- Avoid Using Symbols or Special Characters
- Audit Before You Submit
- Don't Let Your Printer Sabotage Your Claims



*bonus tip: type it, don't write it!

CMS 1500 TUTORIAL



TIME TO TEST YOUR KNOWLEDGE!



1. What is the name of the CMS 1500 form's overseeing body?

A. AHIMA

B. CMS

C. NUCC

D. AAPC

1. What is the name of the CMS 1500 form's overseeing body?

A. AHIMA

B. CMS

C. NUCC ✓

D. AAPC

✓ **Correct Answer: C**

The National Uniform Claim Committee (NUCC) developed and maintains the CMS 1500 claim form.

2. What information is typically entered in item 1a?

- A. Patient's insurance ID number
- B. Diagnosis code
- C. Patient's name
- D. Rendering provider NPI

2. What information is typically entered in item 1a?

- A. Patient's insurance ID number ✓
- B. Diagnosis code
- C. Patient's name
- D. Rendering provider NPI

✓ **Correct Answer: A**

Item 1a is where the insured's ID number is entered. For a Workers' Compensation or Auto No Fault claim, this is where the patient's social security number is entered.

3. What is the place of service (POS) code for office?

A. 10

B. 12

C. 23

D. 11

3. What is the place of service (POS) code for office?

A. 10

B. 12

C. 23

D. 11 ✓

✓ **Correct Answer: D**

POS 11 indicates the service took place in a provider's office.

4. If a patient has secondary insurance, which item would you complete?

A. item 33

B. item 7

C. item 11

D. item 9

4. If a patient has secondary insurance, which item would you complete?

A. item 33

B. item 7

C. item 11

D. item 9 ✓

✓ **Correct Answer: D**

Item 9 captures information about the patient's secondary insurance such as a Medigap policy (Medicare Supplement Insurance).

5. What does "SOF" mean when entered in item 31?

- A. Standard of Form
- B. Signature on File
- C. Source of Funds
- D. Statement of Facts

5. What does "SOF" mean when entered in item 31?

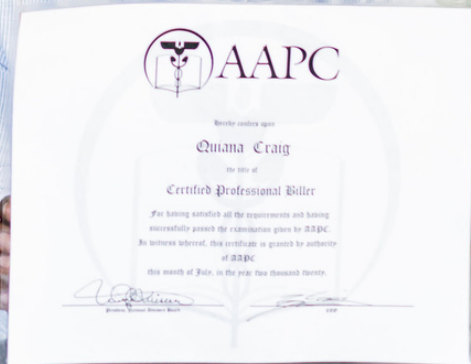
- A. Standard of Form
- B. Signature on File ✓
- C. Source of Funds
- D. Statement of Facts

✓ **Correct Answer: B**

"SOF" is commonly used to indicate that the provider's actual signature is kept on file in the office or facility which eliminates the need to hand sign each claim form.

Who's preparing to take the CPB (Certified Professional Biller) exam?

- Types of insurance (29 questions)
- Billing regulations (17 questions)
- HIPAA and Compliance (7 questions)
- Reimbursement and collections (19 questions)
- Claims and billing (19 questions)
- Coding (10 questions)
- Case analysis (34 questions) CMS 1500 claim forms, Payment policies, LCD, NCD, Appeal letters, Preauthorizations, Accounts receivable reports, Claims follow-up reports





CPB EXAM CASE STUDY PRACTICE QUESTION

NPI: 9876543210

NPI: 8888888888

EIN: 242424523

5678 Blue Street, Here, UT 84848-1234

Patient Information:

Name: Rachel Smith

Address: 1212 My Street

City: Mytown

State: UT

Zip: 44444-1234

Telephone: 801-121-2121

Gender: Female

Status: Married

Date of Birth: 04/01/1973

Employer: John's Towing

Work Related: No

Auto Accident: No

Other Accident: No

Date of Accident: None

Referring Physician: None

Address:

Telephone:

NPI #:

Insurance Information:

Primary Insurance: Medical Insurance Group

Address: PO Box 11111

City: Atlanta

State: GA

Zip: 13451-1234

Policy #: 9999977777

Group #: 80923

Name of Insured: Self

DOS: 8/17/20XX

Procedures: 99202, 72070

Diagnosis: S23.3XXA



HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ BLACK LUNG ☒ OTHER ☐ (Medicare#) (Medicaid#) (ID#(DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S LD. NUMBER (For Program in Item 1) 9999977777									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, RACHEL										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH, RACHEL									
5. PATIENT'S ADDRESS (No., Street) 1212 MY STREET										7. INSURED'S ADDRESS (No., Street) 1212 MY STREET									
CITY MYTOWN					STATE UT					CITY MYTOWN					STATE UT				
ZIP CODE 444441234					TELEPHONE (Include Area Code) ()					ZIP CODE 444441234					TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER 80923									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH ☐ MM ☐ DD ☐ YY ☐ SEX ☐ M ☐ F ☐ 04 01 1973									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										e. INSURANCE PLAN NAME OR PROGRAM NAME MEDICAL INSURANCE GROUP									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO <i>If yes, complete items 9, 9a, and 9d.</i>									
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. SIGNATURE ON FILE																			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE																			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 08 ☐ MM ☐ 17 ☐ DD ☐ 20XX ☐ QUAL. ☐ 431										15. OTHER DATE QUAL. ☐ MM ☐ DD ☐ YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										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)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. S233XXA B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS ON UNITS H. FROST/Frost Per I. LD. QUAL. J. RENDERING PROVIDER ID. #																			
MM ☐ DD ☐ YY ☐ MM ☐ DD ☐ YY ☐ CPT/HCPCS ☐ MODIFIER ☐ DIAGNOSIS ☐ \$ CHARGES ☐ DAYS ON UNITS ☐ FROST/Frost Per ☐ LD. QUAL. ☐ RENDERING PROVIDER ID. #																			
08 17 20XX 11 99202 A 115 00 1 NPI 9876543210																			
08 17 20XX 11 72070 A 60 00 1 NPI 9876543210																			
										NPI									
										NPI									
										NPI									
										NPI									
										NPI									
										NPI									
25. FEDERAL TAX ID. NUMBER SSN ☐ EIN ☒										26. PATIENT'S ACCOUNT NO.									
242424523										27. ACCEPT ASSIGNMENT? ☒ YES ☐ NO									
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.) Michael Johnson MD 08 17 20XX										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # INTERNAL MEDICINE SPECIALISTS 5678 BLUE STREET HERE UT 848481234 a. 8888888888 b. _____									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



5678 Blue Street, Here, UT 84848-1234

Diagnosis: S23.3XXA

HEALTH INSURANCE CLAIM FORM

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

☐ PICA										PICA ☐									
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA-BUS LING ☐ OTHER ☒ (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999997777									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, RACHEL										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH, RACHEL									
3. PATIENT'S BIRTH DATE (MM DO YY) SEX M ☐ F ☒										7. INSURED'S ADDRESS (No., Street) 1212 MY STREET									
5. PATIENT'S ADDRESS (No., Street) 1212 MY STREET										6. RESERVED FOR NUCC USE									
CITY MYTOWN STATE UT										CITY MYTOWN STATE UT									
ZIP CODE 444441234 TELEPHONE (Include Area Code) ()										ZIP CODE 444441234 TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
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)									
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.										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 _____ SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) (MM DO YY) QUAL. 431										15. OTHER DATE (MM DO YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NP1									
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-10 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. S233XXA B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OF LIMITS H. M. PRIOR PLAN I. ID. QUAL. J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN 242424523 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For glos, coding, see back) YES ☒ NO 28. TOTAL CHARGE \$ 175.00 29. AMOUNT PAID \$ 0.00 30. Reval for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
Michael Johnson MD 08 17 20XX SIGNED DATE										33. BILLING PROVIDER INFO & PH # INTERNAL MEDICINE SPECIALISTS 5678 BLUE STREET HERE UT 848481234 34. 8888888888									

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1. Date of Birth
2. Date of service
3. Primary insurance ID number
4. Secondary insurance policy
5. Secondary insurance policy number
6. Secondary insurance group number
7. Place of service
8. Billing provider
9. Provider signature
10. Diagnosis code

Ⓐ 1

(B) I and X

© V, VI, and VII

(D) None of the above

RESOURCES

www.NUCC.org

www.NUBC.org

<https://www.aapc.com/certifications/cpb/taking-the-cpb-exam>

<https://legacy.cigna.com/static/www-cigna-com/docs/health-care-providers/form-cms1500.pdf>

<https://www.ngsmedicare.com/web/ngs/cms-1500-claim-form?selectedArticleId=566219&lob=96664&state=97133&rgion=93623>

<https://www.carelonbehavioralhealth.com/content/dam/digital/carelon/cbh-assets/documents/global/billing-and-claims/cms-1500-claim-form.pdf>

<https://www.cdc.gov/wtc/pdfs/policies/ub-40-P.pdf>

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912>

https://nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2024_07-v12.pdf

www.ICD10data.com

THANK YOU!

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www.JustAskTheBiller.com

