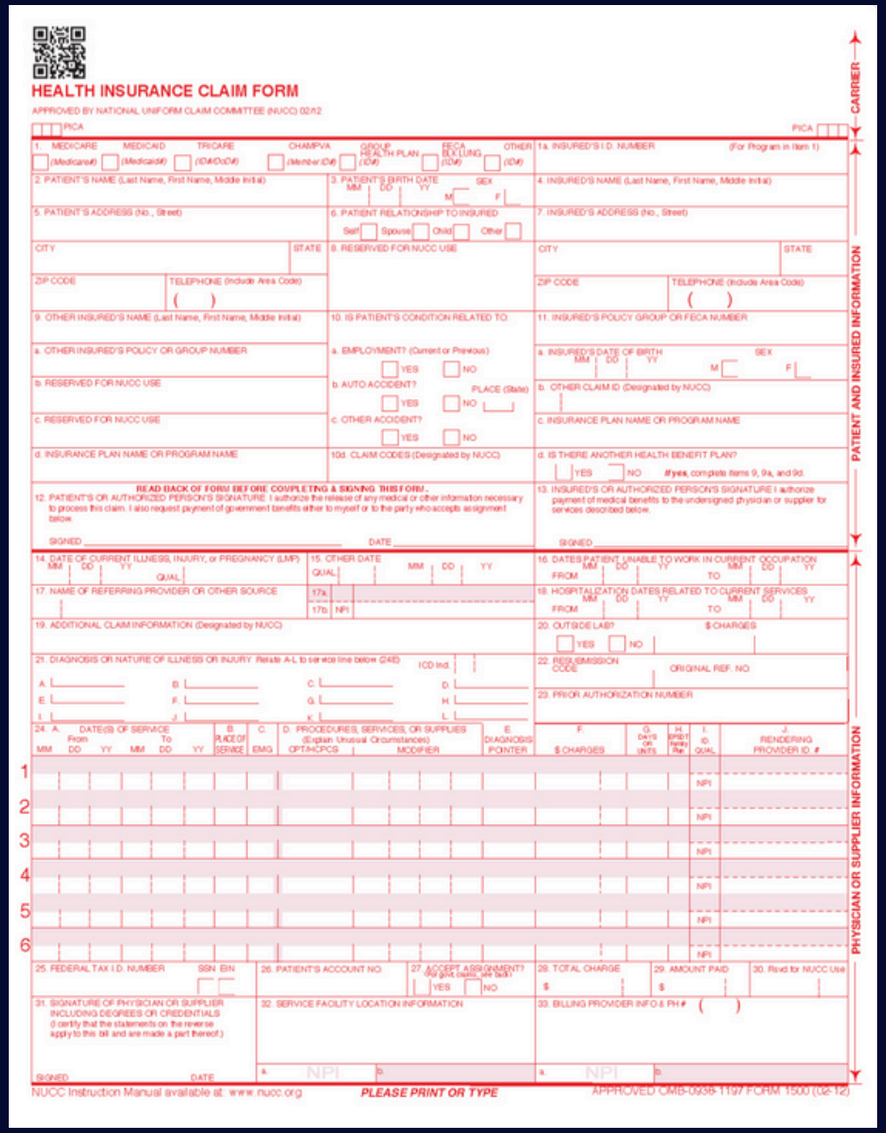
AAPC
LICENSED
EDUCATION PROVIDER

MASTERING THE CMS 1500 CLAIM FORM


HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

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 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 DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

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 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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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. 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI 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

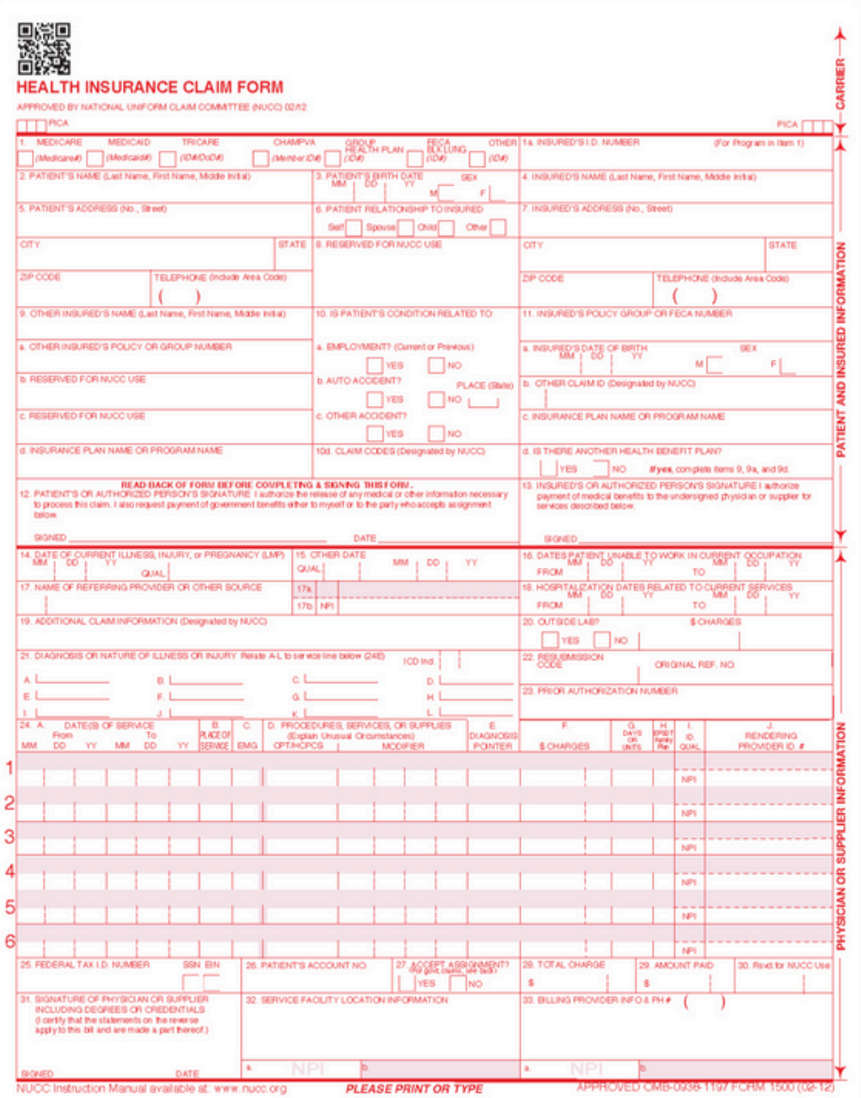
QUIANA CRAIG, CPB, CPB-I, CPC
LICENSED AAPC APPROVED INSTRUCTOR
WWW.JUSTASKTHEBILLER.COM
ASK THE BILLER®

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



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b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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PLEASE PRINT OR TYPE

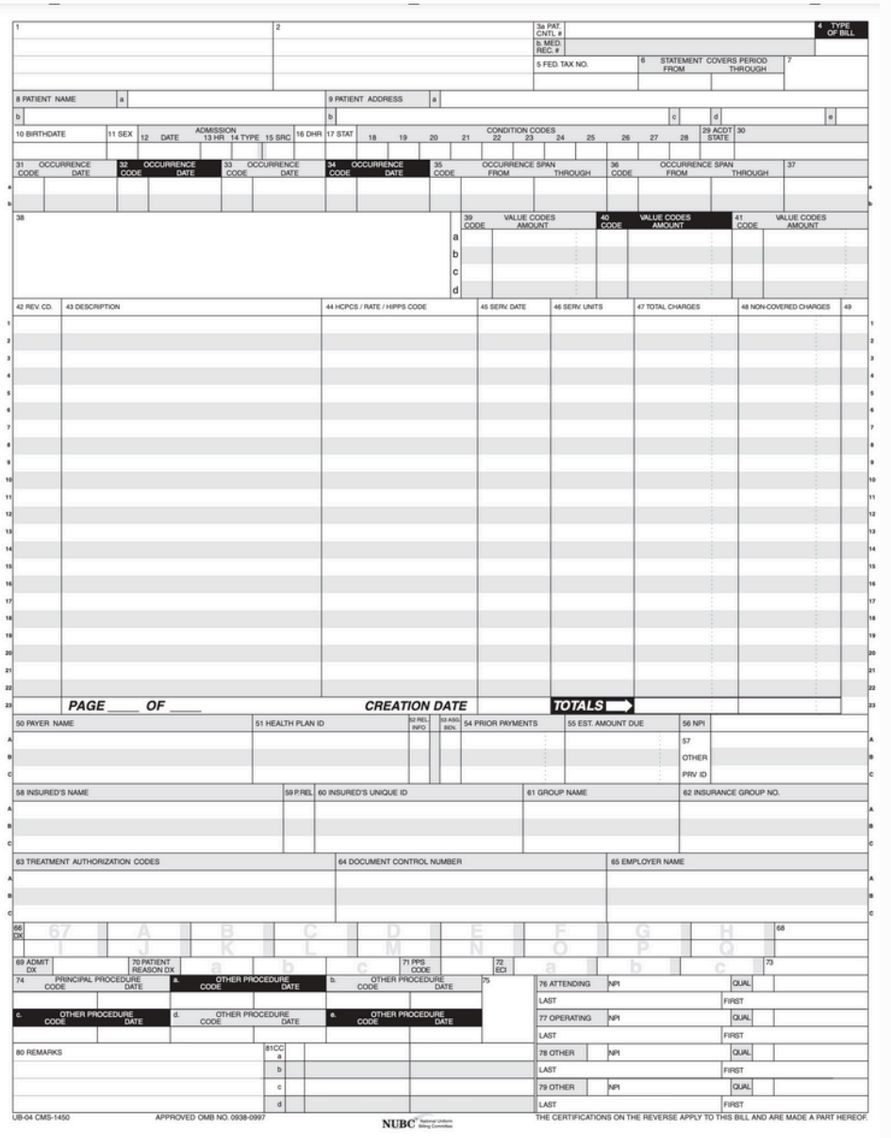
APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS,SEE SEPARATE INSTRUCT10NS ISSUED BY APPLICABLE PROGRAMS.

NOT1CE: Any parson who knowingly fllaa a slalamanlof claim containing any misrepresentation or any false, Incomplata or misleading Information may be guilty of a criminal act punishable under ,__ and may be subject to civil panaHies.

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



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

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CPB EXAM CASE STUDY PRACTICE QUESTION

Provider: Michael Johnson, MD **NPI:** 9876543210

Group: Internal Medicine Specialists **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

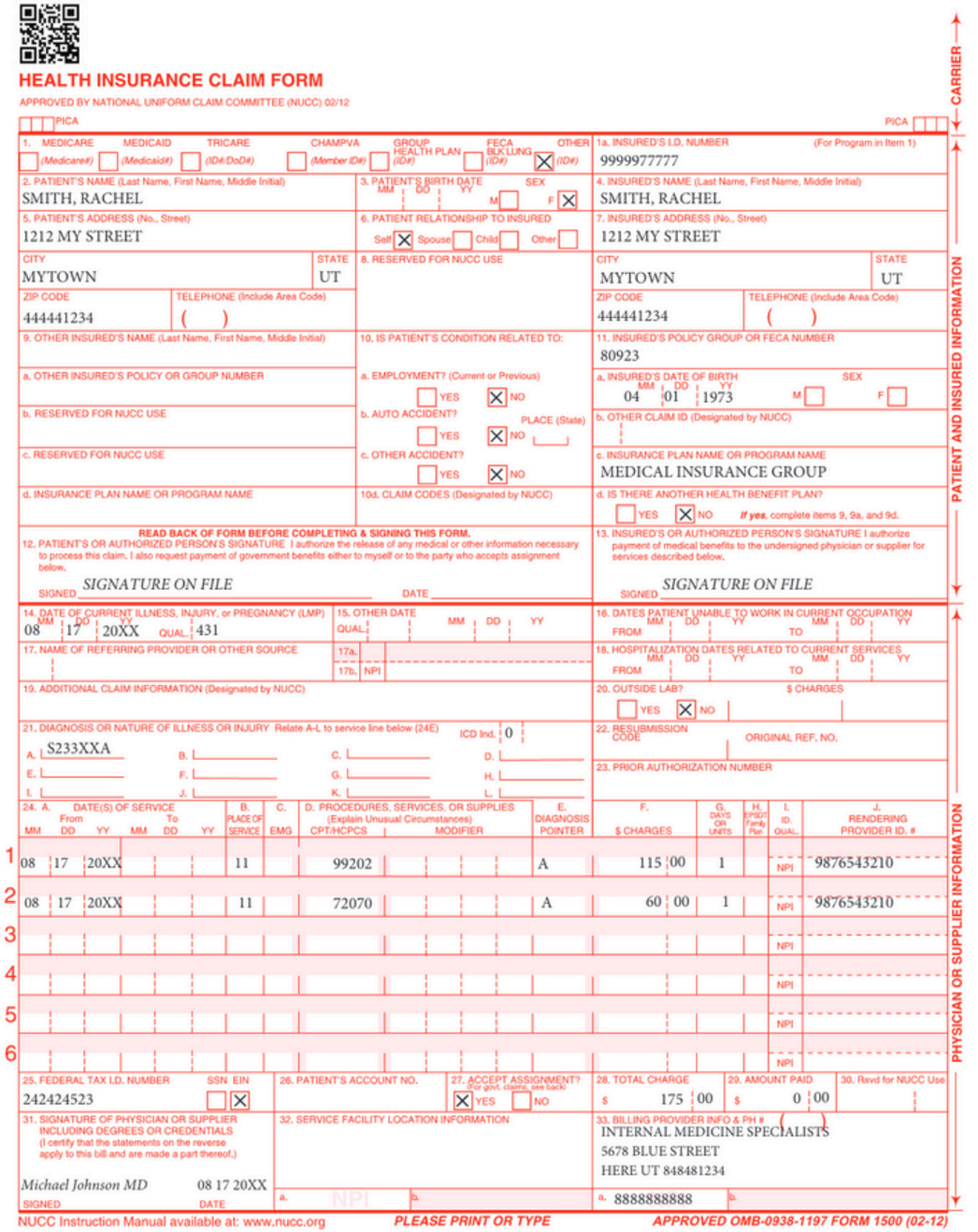
Group #: 80923

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

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) — X OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9999977777

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, RACHEL

3. PATIENT'S BIRTH DATE: SEX — M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, RACHEL

5. PATIENT'S ADDRESS (No., Street): 1212 MY STREET

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 1212 MY STREET

CITY: MYTOWN STATE: UT

8. RESERVED FOR NUCC USE

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 80923

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH: 04 01 1973 SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAL INSURANCE GROUP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *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 *SIGNATURE ON FILE* DATE

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 *SIGNATURE ON FILE*

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 08 17 20XX QUAL 431

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

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20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S233XXA B. C. D. E. F. G. H. I. J. K. L.

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1	08	17	20XX			11		99202		A	115 00	1		NPI	9876543210
2	08	17	20XX			11		72070		A	60 00	1		NPI	9876543210
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 242424523 SSN EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 175 00

29. AMOUNT PAID: $ 0 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.)

Michael Johnson MD 08 17 20XX

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

INTERNAL MEDICINE SPECIALISTS

5678 BLUE STREET

HERE UT 848481234

a. 8888888888 b.

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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

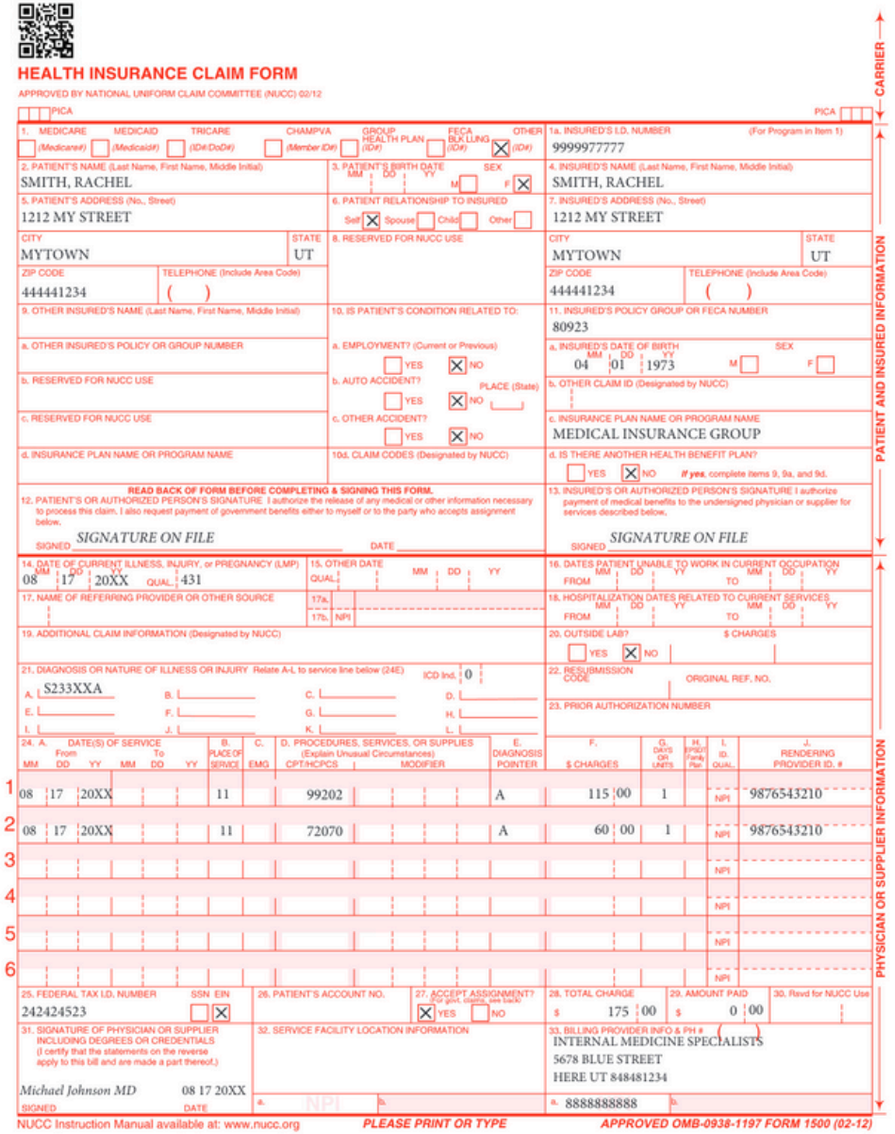
Group #: 80923

Name of Insured: Self

DOS: 8/17/20XX

Procedures: 99202, 72070

Diagnosis: S23.3XXA



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20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S233XXA 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 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 08 17 20XX		11		99202		A	115 00	1		NPI	9876543210
2 08 17 20XX		11		72070		A	60 00	1		NPI	9876543210
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 242424523 X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 175 00

29. AMOUNT PAID: $ 0 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.)

Michael Johnson MD 08 17 20XX

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

After review of the information provided, are there any errors on the claim form? If so, which elements are incorrect?

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

(A) I

(B) I and X

(C) 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
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www.ICD10data.com

THANK YOU!

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