1500 **HEALTH INSURANCE CLAIM FORM**

| | If mailing paper cla | im forms, please submit claims to: |
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| 1500 | Optum Cla | aims |
| HEALTH INSURANCE CLAIM FORM | PO BOX 3 | |
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 | | City, UT 84130-0760 |
| PICA | | PICA |
| 1. MEDICARE MEDICAID TRICARE CHAMPU | r HEALTH PLAN r BLK LUNG r | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) |
| (Medicare #) (Medicaid #) (Sponsor's SSN) (Member | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE SEX | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS (No., Street) |
| | Self Spouse Child Other | |
| CITY STATE | | CITY STATE |
| ZIP CODE TELEPHONE (Include Area Code) | Single Married Other | ZIP CODE TELEPHONE (Include Area Code) |
| | Employed Full-Time Part-Time Student | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | Employed Student Student 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| | | 11280 |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) | a. INSURED'S DATE OF BIRTH SEX |
| | | |
| b. OTHER INSURED'S DATE OF BIRTH SEX | b. AUTO ACCIDENT? PLACE (State) | b. EMPLOYER'S NAME OR SCHOOL NAME University of California |
| | C. OTHER ACCIDENT? | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| C. ENT EVIENT ON SONOUL INAME | | Optum |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? |
| | | YES NO If yes, return to and complete item 9 a-d. |
| READ BACK OF FORM BEFORE COMPLETIN | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize |
| PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eithe below. | | payment of medical benefits to the undersigned physician or supplier for services described below. |
| SIGNED | DATE | SIGNED |
| | IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION |
| MM DD YY INJURY (Accident) OR PREGNANCY(LMP) | GIVE FIRST DATE MM DD YY | FROM TO |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY |
| 17 19. RESERVED FOR LOCAL USE | D. NPI | FROM TO 20. OUTSIDE LAB? \$ CHARGES |
| 19. HESCHVED FOR LOOKE USE | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2 | 3 or 4 to Item 24E by Line) | |
| 1 3 | ↓ ↓ ↓ | CODE ORIGINAL REF. NO. |
| · · 3 | · | 23. PRIOR AUTHORIZATION NUMBER |
| 2 4 | L | |
| | EDURES, SERVICES, OR SUPPLIES E. ain Unusual Circumstances) DIAGNOSIS | F. G. H. I. J. DAYS EFSTUID. RENDERING |
| MM DD YY MM DD YY SERVICE EMG CPT/HC | | \$ CHARGES UNITS Plan QUAL. PROVIDER ID. # |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S | ACCOUNT NO. 27. ACCEPT ASSIGNMENT? | 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE |
| | | \$ \$ \$ |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE F. | | 33. BILLING PROVIDER INFO & PH # () |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | |
| appy to the one and are made a part thereof. | | |
| a. N | DI b. | a. NDI b. |
| SIGNED DATE a. | | |

NUCC Instruction Manual available at: www.nucc.org

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