

COMPLETING THE HCFA 1500 CLAIM FORM

1. Enter an "X" in the appropriate box and indicate proper carrier. (Medicaid)
- 1a. Enter the insured's primary identification number including any letters. Medicaid use Medicaid number from the patient's current Medicaid card.
2. Enter patient's full name. Do not use nicknames or abbreviated names.
3. Enter patient's date of birth in month, day, year format. Enter an "X" to indicate appropriate sex.
4. Enter the insured full name, unless the patient is the insured, then enter the word "Same".
5. Enter the patient's complete address.
6. Check the appropriate box on the relationship to the insured.
7. If the insured's address is the same as the patient's then enter "Same".
8. Enter patient's status in the appropriate box.
9. If the patient has other insurance, enter the name of the policyholder here.
- 9a. Enter the other insured's policy or group number.
- 9b. Enter the other insured's date of birth.
- 9c. Enter the employer of the other insured.
- 9d. Enter the plan or program name of the secondary insurance.
11. Enter the insured's group number (Medicaid, can use Medicaid ID number), date of birth, and check the appropriate box on other coverage.
12. Have the insured or appropriate guardian (if under 18 years old) complete the Consent to Release Information form (copy is provided in the Sample Clinical Forms section of this manual). If form is complete and in patients chart, enter "On File".
13. Insured must sign box, to send payment for services to the provider. (Medicaid has an automatic assignment of benefits).
14. If known, enter the date of onset for services rendered for illness.
21. Enter the diagnosis in this space.
23. Enter the corresponding authorization number for the services being billed here.
- 24 a. Enter date of service.
- 24d. Enter the proper procedure code from your Medicaid contract or the Referral Authorization Letter.
- 24e. Enter the appropriate ICD9-CM diagnosis.
- 24f. Enter the charge for the service.
- 24g. Enter the number of days or units.
25. Enter the Social Security number (SSN) or Federal Employer Identification Number (FEIN) and mark an "X" in the appropriate box to indicate which is being used.
26. Enter your patient's account number.
28. Enter the total of all charges listed in Section 24 Column F.
31. The physician (or authorized representative) must sign the provider's name and enter the date.
32. Enter the name and address of facility where services were rendered.
33. Enter the physicians billing name and address, including the Provider's Medicaid number.