The Revised CMS-1500 Form ... at a Glance

The Office of Management and Budgets (OMB) has approved a revised CMS-1500 health insurance claim form (version 02/12) to replace the current form (version 08/05). TFP Data Systems, the designated provider of the form, worked directly with the National Uniform Claim Committee (NUCC) on the form's development and distribution.

The revisions, which better align the CMS-1500 with certain changes in the electronic Health Care Claims, are:

1 1500 symbol replaced with a scannable QR code that takes the user to the NUCC CMS-1500 landing page.	> (1											
31 3	1		EALTH INSURANC										
		APF	PROVED BY NATIONAL UNIFORM	CLAIM COMMIT	TEE (NUC	C) 02/12						DICA CT	
2 1 – Minor changes to the wording		1.	MEDICARE MEDICAID	TRICARE		CHAMPVA GROU	UP	FECA OTHER	1a. INSURED'S I.D. NU	MBER	(For Program in Item 1)	
of payer ID number requirements.	→ €	2]	(Medicare#) (Medicaid#)	(ID#/DoD#)		(Member ID#) HEAL (ID#)	UP .TH PLAN	FECA OTHER BLK LUNG (ID#)					
		2.1	PATIENT'S NAME (Last Name, First	Name, Middle In	itial)	3. PATIENT'S	BIRTH DAT	E SEX	4. INSURED'S NAME (L	ast Name,	First Name, Mid	ddle Initial)	
		5.	PATIENT'S ADDRESS (No., Street)			6. PATIENT F	RELATIONSH	IP TO INSURED	7. INSURED'S ADDRES	SS (No., Str	eet)		
3 8 - Changed to "RESERVED FOR NUCC USE"		L				Self	Spouse	Child Other					
("PATIENT STATUS" removed from the form).		CIT	A.			STATE 8. RESERVE	D FOR NUCC	USE	CITY			STATE	
(FATIENT STATOS TETHOVEG ITOTT THE TORM).		ZIF	P CODE TEL	EPHONE (Includ	e Area Co	ide)			ZIP CODE	1	TELEPHONE (I	nclude Area Code)	
		L	()							()		
		9. (OTHER INSURED'S NAME (Last Na	me, First Name,	Middle Ini	tial) 10. IS PATIEN	NT'S CONDIT	ION RELATED TO:	11. INSURED'S POLICY	GROUP C	OR FECA NUME	3ER	
4 9b and 9c – Replaced with "RESERVED		a. /	OTHER INSURED'S POLICY OR GE	OUP NUMBER		a. EMPLOYM	MENT? (Curre	nt or Previous)	a. INSURED'S DATE OF	F BIRTH		SEX	
FOR NUCC USE" ("EMPLOYER'S NAME OR		b	RESERVED FOR NUCC USE			b auto acc	YES CIDENT?	NO			М	F	
SCHOOL NAME" removed from the form).			NECETIVED FOR NOOD OOL			10.201020	YES	PLACE (State)	b. OTHER CLAIM ID (D	esignated t	y NUCC)	6	
•	\rightarrow	4	ESERVED FOR NUCC USE			c. OTHER AC			c. INSURANCE PLAN N	IAME OR P	ROGRAM NAM	IE .	
			INCLIDANCE DI AN NAME OD DDO	SDAM NAME		10d CLAIM C	YES (Decide	NO anated by NUCC)	d. IS THERE ANOTHER	UEALTH I	DENICEIT DI ANI	· ·	
5 10d – Changed to "CLAIM CODES —		0.1	TOOTS TO SET TO THE OTT TO	arran remit	\rightarrow	5 10d. CLAIN C	JODEO (DOS)	initiod by 11000)	YES N	NO #	yes, complete it	ems 9, 9a, and 9d.	
(Designated by NUCC)."		12	READ BACK PATIENT'S OR AUTHORIZED PER	OF FORM BEF	ORE COL	MPLETING & SIGNING T	THIS FORM.	r information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize				
(5 cs.g. (acca 5) 110 cc).			to process this claim. I also request p below.	ayment of govern	ment ben	efits either to myself or to the	the party who a	accepts assignment	services described b	elow.	•		
		L	SIGNED			DAT	TE		SIGNED				
6 11b – Changed to "OTHER CLAIM ID		7 14	14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL.							16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO			
(Designated by NUCC)."		QUAL. QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 8							18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
(Designated by NOCC).	II des		9			17b. NPI			FROM	- "	то		
	Ш.	19.	ADDITIONAL CLAIM INF	N (Designated b	y NUCC)	T			20. OUTSIDE LAB?	NO	\$ CHA	RGES 	
14 Nines shanges to leveut of fold	11 11 1	21.	. DIAGNOSIS OR NATURE OF ILLN	ESS OR INJURY	Relate A	A-L to service line below (2	24E) ICD	Ind.	22. RESUBMISSION		DRIGINAL REF.	NO.	
7 14 – Minor changes to layout of field.	2 11 1	A.	в. і		_	c. L	_	D	23. PRIOR AUTHORIZA			. No.	
	4 111	E.	F. I		_	G. L	_	н. Ц.	23. PHIOH AUTHORIZA	TION NOW	IBEH		
	, 111	24	. A. DATE(S) OF SERVICE	B. PLACE OF	C. [). PROCEDURES, SERV	/ICES, OR SU	PPLIES E.	F.	G. DAYS E	H. I.	J. RENDERING	
8 15 – Removed "IF PATIENT HAS HAD SAME	ш	M	From To	YY SERVICE	EMG	CPT/HCPCS	MODIFIE	R POINTER	\$ CHARGES	OR F	Plan QUAL.	PROVIDER ID. #	
OR SIMILAR ILLNESS, GIVE FIRST DATE."	עקע	1									NPI		
ON SHARE AND EACH OF THE STREET		2											
	. II										NPI		
17 – Added a field to report a qualifier to		3									NPI		
identify which provider is being reported.		4											
identity which provider is being reported.											NPI		
		5									NPI		
21 Added eight additional lines for		6									NPI		
21 – Added eight additional lines for diagnosis or nature of illness/injury.		25	. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PA	TIENT'S ACCOUNT NO.	27. AC	CCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. A	MOUNT PAID	30. Rsvd for NUCC Us	
		L			-			rES NO	s	\$		111	
		31.	SIGNATURE OF PHYSICIAN OR S INCLUDING DEGREES OR CREDI (Logrify that the statements on the	ENTIALS	32. SE	RVICE FACILITY LOCAT	TION INFORM	ATION	33. BILLING PROVIDER	R INFO & PI	н# ()	
	1		apply to this bill and are made a par									1	
		$\overline{}$				MD/ F			a NIDI	L			
("BALANCE DUE" removed from the form).		SIC	SIGNED DATE a. D. D. DATE DATE DATE DATE DATE DATE DATE DATE								OMB	ADDDOVAL DENDIN	
		NU	OC INSTRUCTION MARIUM AVAI	avie at: WWV	v.nucc.(ng PLE.	AGE PRIN	OR TIPE			OMB	ALT THOUGHT PENDIN	
30 – Replaced with "Rsvd for NUCC Use" ("BALANCE DUE" removed from the form).		SIC	(I certify that the statements on the apply to this bill and are made a par GNED	t thereof.)	a. v.nucc.o	NPI b.	EASE PRIN	IT OR TYPE	a. NPI	b.	OMB	APPROVAL PENDI	