**Example of Form CMS-1500 version 02/012, “Health Insurance Claim Form”**

The image contains a full Health Insurance Claim Form (CMS-1500) which is used to submit claims for reimbursement of medical services. The form includes sections for patient information, insurance details, date of service, diagnosis, and billing information. Each section is designed to capture specific details required for a medical claim.

For a more detailed review, you can access the full PDF version of the form through the provided link or service.
BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amounts paid by the Government as payment in full. See Black Lung and FECA instructions regarding prepayment and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: (a) the information on this form is true, correct and complete; (b) I have honored myself with all applicable laws, regulations and program instructions, which are available to me; and (c) I have provided or will provide sufficient information and services to fully comply with the requirements of the Medicare program.

NOTICE TO PATIENT ABOUT THE USE AND DISCLOSURE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, HHS, and DoD to ask for information needed to administer the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is as follows: 50a, 180, 1902, 1903 of the Social Security Act. An amendment, 42 CFR 411.24 and 414.50, and 19 USC 1395f to the Social Security Act. The information we obtain to comply with these laws is used to identify you and to determine your eligibility. It is also used to decide if services are covered by these programs and to determine payment amounts.

Not all Medicare benefits may be paid unless this form is received as required by law and regulations. This may be done at the discretion of the Medicare provider or beneficiary, and in such a case, the Medicare provider or beneficiary may be billed for the services.

NOTICE TO PATIENT ABOUT THE USE AND DISCLOSURE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION

We are authorized by CMS, HHS, and DoD to ask for information needed to administer the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is as follows: 50a, 180, 1902, 1903 of the Social Security Act. An amendment, 42 CFR 411.24 and 414.50, and 19 USC 1395f to the Social Security Act.

The information we obtain to comply with these laws is used to identify you and to determine your eligibility. It is also used to decide if services are covered by these programs and to determine payment amounts.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby swear to keep such records as are necessary to disclose the extent of services provided to individuals under the Social Security Act and to furnish information regarding any payments claimed for providing such services to the State or City of Health and Human Services may request.

I further swear that this statement is true, correct and complete, and that I will comply with all laws, regulations and program instructions, which are available to me.
471-000-58 Example of Form CMS-1500, “Health Insurance Claim Form”

Version 08/05, no longer accepted as of April 1, 2014
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 law and may be subjected to civil penalties.

REFERENCES TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature ensures that the claim submitted is true, accurate and complete. In the case of a Medicare claim, the provider is authorized to release information in the files of the provider to Medicare or other third-party payers for the purpose of auditing. The signature also authorizes release of the information to the provider of care or agency, where it is used for auditing purposes. See 42 CFR 411.24(a). If item G is completed, the provider's signature authorizes release of the information to the provider of care or agency, where it is used for auditing purposes. In Medicare-assigned or CHAMPUS participation, the provider agrees to accept the charge for the service rendered and to provide services at the same rate charged for the service rendered.

BLACK LUNG AND FECA CLAIMS

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services provided to the patient are medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For the services to be considered "incident" to a physician's professional services, 1) they must be rendered under the physician's immediate personal supervision by his employee; 2) they must be an integral part of a covered physician's service; 3) they must be furnished to the patient at the physician's office; and 4) the services of nonphysicians must be included on the physician's bills. For CHAMPUS claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military. I further certify that the services performed were for a black lung-related disorder.

DISCLOSURES: Voluntary, however, failure to provide information in result in denial of payment. See 42 CFR 411.24(a) and 422.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq. and 10 USC 1079 and 1088; 5 USC 8101 et seq. and 30 USC 901 et seq.; 38 USC 813; E.O. 9371.

The information we obtain to determine eligibility and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by these programs and to ensure that proper payment is made.

We are authorized by CMS, CHAMPUS and OWCP to ask for information related to the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is section 205(a), 1962, 1072 and 1074 of the Social Security Act, as amended. 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq. and 10 USC 1079 and 1088; 5 USC 8101 et seq. and 30 USC 901 et seq.; 38 USC 813; E.O. 9371.

The information we obtain to determine eligibility and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by these programs and to ensure that proper payment is made. We also use the information to determine if you are eligible for benefits under the Social Security Act, as amended. 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq. and 10 USC 1079 and 1088; 5 USC 8101 et seq. and 30 USC 901 et seq.; 38 USC 813; E.O. 9371.

Routine Uses: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or their statutory administrative subdivisions for disclosure under CHAMPUS, FECA, Medicare and Medicaid programs. Information may be shared with the Dept. of Justice for investigation of fraud and abuse. Information may be shared with the Social Security Administration for the administration of the Social Security Act. Information may also be shared with the Medicare, Medicaid and other programs.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Medicaid program and to furnish information regarding any payments made for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of any allowable appeal or adjustment payment or similar cost as authorized by law.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0906-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: FHA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1599. The address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.