

Adult Foster Care (AFC)

APPROVED BY NATIONAL UNIFO	RM CLAIM COMMITTEE (N	NUCC) 02/12									
PICA										PICA	
1. MEDICARE MEDICA		CHAME	┌── ĤEĂÌ	LTH PLAN —— BLK LU	JNG OTHER				(For F	Program in Item 1)	
(Medicare #) (Medicaid	<u> </u>	(Membe	, , , , , , , , , , , , , , , ,	(ID#)	(ID#)	1234567					
2. PATIENT'S NAME (Last Name,	First Name, Middle Initial)		3. PATIENT'S I	ו חו	SEX	4. INSURED'S NA	•	e, First Name	, Middle I	nitial)	
DOE, JOHN M.				1 1950 MX		,		Dave est)			
5. PATIENT'S ADDRESS (No., Str			6. PATIENT RE			7. INSURED'S AD					
123 ABC STREET				Spouse Child	Other	123 ABC	STREE.	T.			
CITY		STATE	8. RESERVED	FOR NUCC USE		CITY				STATE	
ANYTOWN	TELEBLIONE (In alcale As	TX				ANYTOWN		1		TX	
ZIP CODE	TELEPHONE (Include Ar	rea Code)				ZIP CODE		,	1	e Area Code)	
77777	()					77777		`		56-7890	
9. OTHER INSURED'S NAME (La	st Name, First Name, Midd	dle Initial)	10. IS PATIENT	I'S CONDITION RELAT	ED TO:	11. INSURED'S P	OLICY GROUP	P OR FECA N	UMBER		
a. OTHER INSURED'S POLICY O	P CPOLID NILIMBED		514BL 0144	ENTO (O		a INCLIDEDIC DA	TE OF DIDTU			SEX	
a. OTTEN INSONED S FOLIOT O	H GHOOF NOMBER		a. EMPLOYM	ENT? (Current or Prev		a. INSURED'S DA'	DD YY				
b. RESERVED FOR NUCC USE					10	i otuse ou una	<u>i</u>		М	F	
b. RESERVED FOR NOCC OSE			b. AUTO ACC		PLACE (State)	b. OTHER CLAIM	ID (Designated	d by NUCC)			
- DECEDIED FOR \$1100 1107					10	- INOLIDATION TO	ANI NIAN 45 CT	, ppocs	10045		
c. RESERVED FOR NUCC USE			c. OTHER AC		10	c. INSURANCE PL		R PROGRAM N	NAME		
				YES 1	10	HMO NAM					
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM Co	ODES (Designated by	NUCC)	d. IS THERE ANO					
						YES		yes, complet			
12. PATIENT'S OR AUTHORIZED	BACK OF FORM BEFORE PERSON'S SIGNATURE 1.2				necessary	13. INSURED'S Of payment of me				URE I authorize ysician or supplier	for
to process this claim. I also re-						services descr			J 1 .		
below. STGNATIIR	E ON FILE						SIGNATU	IDE ON	ם.דד.ם	1	
SIGNED		v (LMD). Lac	DATE			SIGNED					
14. DATE OF CURRENT ILLNESS	1		OTHER DATE	MM DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY					
17. NAME OF REFERRING PROV						FROM 18. HOSPITALIZA	TION DATES E		CURRENT	I SERVICES	
!	IDEN ON OTHER GOORGE	E 17a. 17b.				MM		YY	MM	DD YY	
19. ADDITIONAL CLAIM INFORM	ATION (Designated by NII)		. INFI			FROM 20. OUTSIDE LAB	?		CHARGI	<u>i i</u> FS	
10. ABBITIONAL OB IIIVI IN OTIM	Triory (Boolghated by 140	.00)				YES	No l	•	011111101		
21. DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY Rela	ate A-L to service	ce line below (24	E) ICD Ind. 9		22. RESUBMISSIC					
				, ICD Ind.; 9	i	CODE		ORIGINAL R	REF. NO.		
A. <u> 799.99</u>	В	C.		D. L		23. PRIOR AUTHO	DRIZATION NU	IMBER			
E. L.	F	G.		H. L							
24. A. DATE(S) OF SERVICE	J. B. C	K.	EDLIBES SERVI	L. L CES, OR SUPPLIES		F.	G.	H. I.		J.	
From	TO PLACE OF	(Expla	in Unusual Circu	ımstances)	DIAGNOSIS		G. DAYS OR	EPSDT ID.		RENDERING	
MM DD YY MM D	D YY SERVICE EM	IG CPT/HCF	CS	MODIFIER	POINTER	\$ CHARGES	UNITS	Plan QUAL.		ROVIDER ID. # LZA0620X	
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		1				1		NPI	+		
				<u> i i </u>							
						1		NPI	+		
25. FEDERAL TAX I.D. NUMBER	SSN EIN 2	26. PATIENT'S A	ACCOUNT NO.	27. ACCEPT AS (For govt. claim	SIGNMENT?	28. TOTAL CHARG	GE 2	9. AMOUNT F	PAID	30. Rsvd for NUC	CC Use
740001243		-		(For govt. claim	s, see back) NO		19 20		- 1		20
31. SIGNATURE OF PHYSICIAN		32. SERVICE FA	CILITY LOCATION	ON INFORMATION		33. BILLING PROV			123)	456-7890	
INCLUDING DEGREES OR C (I certify that the statements of		ABC HOM	E HEALT	Н		ABC HOM	E HEALT	•	/		
apply to this bill and are made			ING STR			123 CAR					
SIGNATURE ON FILE		ANYTOWN	I, TX 77	770		ANYTOWN	, TX 77	770			
CIONED	DATE	NPI N	DI b.			a. NP	h	. 311ZA	0620	X	
SIGNED	DATE	TAT T	[INF.	- "	JIIIA	020	21	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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



Assisted Living

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

PICA						PICA PICA
1. MEDICARE MEDICAID TRICA	ARE CHAME	PVA GROUP HEALTH PLAI	FECA OTHEF	1a. INSURED'S I.D. NUMBER		(For Program in Item 1)
(Medicare #) (Medicaid #) (ID#D	OOD#) (Membe	r ID#) (ID#)	(ID#)	123456789		
2. PATIENT'S NAME (Last Name, First Name, Mid	ddle Initial)	3. PATIENT'S BIRTH DA	YY — —	4. INSURED'S NAME (Last Nam	e, First Name,	Middle Initial)
DOE, JOHN M.		01 01 19	950 M X F	DOE, JOHN M.		
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONS	SHIP TO INSURED	7. INSURED'S ADDRESS (No., S		
123 ABC STREET		Self Spouse	Child Other	123 ABC STREET	[
CITY	STATE	8. RESERVED FOR NU	CC USE	CITY		STATE
ANYTOWN	TX			ANYTOWN		TX
ZIP CODE TELEPHONE	(Include Area Code)			ZIP CODE	TELEPHONE	(Include Area Code)
77777 ()				77777	(12	3) 456-7890
9. OTHER INSURED'S NAME (Last Name, First N	lame, Middle Initial)	10. IS PATIENT'S CONE	DITION RELATED TO:	11. INSURED'S POLICY GROUP	OR FECA NU	JMBER
a. OTHER INSURED'S POLICY OR GROUP NUM	1BER	a. EMPLOYMENT? (Cu	urrent or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY		SEX
		YES	S NO		l	M F
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (Designated	l by NUCC)	
		YES	S NO NO			STATE TX E (Include Area Code) 3) 456-7890 JMBER SEX M F
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	?	c. INSURANCE PLAN NAME OR	PROGRAM N	AME
		YES	S NO	HMO NAME		
d. INSURANCE PLAN NAME OR PROGRAM NA	ME	10d. CLAIM CODES (De	esignated by NUCC)	d. IS THERE ANOTHER HEALTH	BENEFIT PLA	N?
				YES X NO II	yes, complete	e items 9, 9a and 9d.
	M BEFORE COMPLETING			13. INSURED'S OR AUTHORIZE		
 PATIENT'S OR AUTHORIZED PERSON'S SIGN to process this claim. I also request payment of 				payment of medical benefits services described below.	to the undersi	gned physician or supplier for
below.						
SIGNATURE ON FI	LE	DATE		SIGNED SIGNATU	JRE ON	FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PF	REGNANCY (LMP): 15.	OTHER DATE	M i DD i YY	16. DATES PATIENT UNABLE TO	O WORK IN CL	JRRENT OCCUPATION MM DD YY
MM DD YY QUAL.	Ql	JAL. MN	M DD YY	MM DD `	T T	
17. NAME OF REFERRING PROVIDER OR OTHE	R SOURCE 17a.			18. HOSPITALIZATION DATES F	RELATED TO C	CURRENT SERVICES MM DD YY
	17b.	NPI		FROM	т.	
19. ADDITIONAL CLAIM INFORMATION (Designa	ated by NUCC)			20. OUTSIDE LAB?	\$	CHARGES
				YES NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR IN	JURY Relate A-L to service	e line below (24E)	ICD Ind. 9	22. RESUBMISSION CODE	ORIGINAL RE	E NO
A. [799.99] B. [C.		D			11.110.
E. L F. L	G.		н. Ц	23. PRIOR AUTHORIZATION NU	MBER	
I J	K.		L			
		EDURES, SERVICES, OR		F. G. DAYS	H. I. EPSDT ID	J. RENDERING PROVIDER ID. #
From To PL MM DD YY MM DD YY SE		in Unusual Circumstance CS MODI		\$ CHARGES UNITS	Family ID. Plan QUAL.	RENDERING PROVIDER ID. #
					ZZ	310400000X
02 01 14 02 15 14	13 T20	31 99 U3	U1 U1 1	729 90 15	NPI	NPI
						310400000X NPI
					NPI	
					NPI	
					NPI	
					NPI	
					NPI	
25. FEDERAL TAX I.D. NUMBER SSN I	EIN 26. PATIENT'S A	ACCOUNT NO. 27	. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 2	9. AMOUNT PA	AID 30. Rsvd for NUCC Use
740001234			YES NO	\$ 729 90	\$	729 90
31. SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE FA	CILITY LOCATION INFO	RMATION	33. BILLING PROVIDER INFO &	PH# (1	.23) 456-7890
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		IE HEALTH		ABC HOME HEALT	Н	•
apply to this bill and are made a part thereof.	123 CAN	ING STREET		123 CARING STR		
SIGNATURE ON FILE	ANYTOWN	T, TX 77770		ANYTOWN, TX 77	770	
SIGNED DATE	a. NPI	D. b.		a. NPI b	310400	0000X



Day Activity & Health Services (DAHS)

PPROVED BY NATIONAL	LINIFORM CLAIM COMMITTEE (NLICC) 02/12	

PICA										PICA T
1. MEDICARE MEDICA	ID TRICARE	CHAME	PVA GROUP HEALTH	FECA PLAN BLK LUI	OTHER	1a. INSURED'S I.E). NUMBER		(For Progra	am in Item 1)
(Medicare #) (Medicaid	(ID#DOD#)	(Membe	r ID#) HEALTH	PLAN BLK LUN	NG (ID#)	1234567	89			
2. PATIENT'S NAME (Last Name,	First Name, Middle Initia	<u> </u>	3. PATIENT'S BIRT		SEX	4. INSURED'S NA	ME (Last Nam	e, First Name	e, Middle Initial)	
DOE, JOHN M.			MM DD 01 01	1950 MX	F	DOE, JOI	HN M.			
5. PATIENT'S ADDRESS (No., St	reet)			TONSHIP TO INSUF	RED	7. INSURED'S AD	DRESS (No., S	Street)		
123 ABC STREET	ı		Self Spo	use Child	Other	123 ABC	STREET	Γ		
CITY		STATE	8. RESERVED FOR		Other	CITY				STATE
ANYTOWN		TX	6. RESERVED I OF	TNOCC OSE		ANYTOWN				TX
ZIP CODE	TELEPHONE (Include A							TEL EDU 0		
	/ \	Area Code)				ZIP CODE		,	NE (Include Area	
77777	()					77777			23) 456-	-7890
9. OTHER INSURED'S NAME (La	st Name, First Name, Mic	ddle Initial)	10. IS PATIENT'S C	CONDITION RELATE	D TO:	11. INSURED'S PO	OLICY GROUP	OR FECA N	NUMBER	
a. OTHER INSURED'S POLICY C	R GROUP NUMBER		a. EMPLOYMENT	? (Current or Previo	us)	a. INSURED'S DAT	TE OF BIRTH		SEX	
				YES NO)				М	F
b. RESERVED FOR NUCC USE			b. AUTO ACCIDE	NT?	PLACE (State)	b. OTHER CLAIM I	D (Designated	by NUCC)		
				YES NO						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDI	ENT?		c. INSURANCE PL	AN NAME OR	PROGRAM	NAME	
				YES NO)	HMO NAMI	F			
								DENICETE:	ANIO	
d. INSURANCE PLAN NAME OF	PROGRAM NAME		10d. CLAIM CODE	S (Designated by N	UCC)	d. IS THERE ANOT				
						YES			ete items 9, 9a a	
READ I 12. PATIENT'S OR AUTHORIZED	BACK OF FORM BEFOR PERSON'S SIGNATURE.				ecessarv	13. INSURED'S OF payment of me				authorize n or supplier for
to process this claim. I also re						services descri			9	
below.	D ON DITE					,	3 T C313 FF	TDE 011		
SIGNED SIGNATUR	E ON FILE		DATE _			SIGNED	SIGNATU	JRE ON	FILE	
14. DATE OF CURRENT ILLNESS	, INJURY, or PREGNAN	CY (LMP): 15.	OTHER DATE	MM _I DD _I	YY	16. DATES PATIEN	IT UNABLE TO	O WORK IN O	CURRENT OCC	UPATION ID I YY
IVIIVI DD 1 11 QU	AL.	QL	JAL.	IVIIVI DD	11	FROM	ו		TO VIIVI	ו ויי
17. NAME OF REFERRING PROV	IDER OR OTHER SOUR	CE 17a.				18. HOSPITALIZAT				RVICES
		17b.	NPI			FROM I	DD ,	YY	TO !	ו ו טי
19. ADDITIONAL CLAIM INFORM	ATION (Designated by N	IUCC)				20. OUTSIDE LAB?	?		\$ CHARGES	
						YES	NO			
21. DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY R	elate A-L to service	e line below (24E)	ICD Ind. 9		22. RESUBMISSIO				
			,	ICD Ind.; 9		CODE		ORIGINAL I	REF. NO.	
A. <u>799.99</u>	В			D. L		23. PRIOR AUTHO	RIZATION NU	MBER		
E	F	_ G.		н. 📖		2011110117101110				
I. L	J	_ K.		L. L.						
24. A. DATE(S) OF SERVICE From	B. FLACE OF		DURES, SERVICES		E. DIAGNOSIS	F.	G. DAYS	H. I. EPSDT ID.		J. ERING
MM DD YY MM [in Unusual Circumst CS N	MODIFIER	POINTER	\$ CHARGES	OR UNITS	Family ID. Plan QUAI		DER ID. #
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25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S A	ACCOUNT NO.	27. ACCEPT ASS (For govt. claims,		28. TOTAL CHARG	SE 25	9. AMOUNT	PAID 30.	Rsvd for NUCC Use
740001234				YES	NO NO	\$ 3	09 98	\$		309 98
31. SIGNATURE OF PHYSICIAN		32. SERVICE FA	CILITY LOCATION II		_	33. BILLING PROV		PH# (123) 45	6-7890
INCLUDING DEGREES OR C (I certify that the statements of		ABC HOM	IE HEALTH			ABC HOME	E HEALT	•	,	
apply to this bill and are mad			ING STREE	Т		123 CAR				
SIGNATURE ON FILE			T, TX 7777			ANYTOWN				
						a NIF		0.55	0.600==	
	DATE	a. NPI	b .			a. NPI	b	· 2610	X0600X	



Emergency Response

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

PICA		- (- 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0						PICA T
MEDICARE MEDICAI	D TRICARE	CHAME	PVA GROUP HEALTH PLAN	FECA	OTHER	1a. INSURED'S I.D. NUMBER		(For Program in Item 1)
(Medicare #) (Medicaid	#) (ID#DOD#)	(Membe	r ID#) HEALTH PLAN (ID#)	(ID#)	(ID#)	123456789		
2. PATIENT'S NAME (Last Name,	First Name, Middle Initi	al)	3. PATIENT'S BIRTH DA	~	SEX	4. INSURED'S NAME (Last Na	me, First Name,	Middle Initial)
DOE, JOHN M.			01 01 19	50 MX	F	DOE, JOHN M.		
5. PATIENT'S ADDRESS (No., Stre	eet)		6. PATIENT RELATIONS	SHIP TO INSUF	RED	7. INSURED'S ADDRESS (No.	•	
123 ABC STREET			Self Spouse	Child	Other	123 ABC STREE	ET	
CITY		STATE	8. RESERVED FOR NUC	CC USE		CITY		STATE
ANYTOWN		TX				ANYTOWN		TX
ZIP CODE	TELEPHONE (Include	Area Code)				ZIP CODE	TELEPHONE	E (Include Area Code)
77777	()					77777	(12	23) 456-7890
9. OTHER INSURED'S NAME (Las	t Name, First Name, Mi	iddle Initial)	10. IS PATIENT'S COND	ITION RELATE	D TO:	11. INSURED'S POLICY GRO	UP OR FECA NU	JMBER
OTHER MOURERIO POLICY OF	000101111111000							057
a. OTHER INSURED'S POLICY OF	R GROUP NUMBER		a. EMPLOYMENT? (Cu	rrent or Previo	us)	a. INSURED'S DATE OF BIRTH		SEX
IN DECEDIED FOR AUTOCATOR			YES	NO.)			M F
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?		PLACE (State)	b. OTHER CLAIM ID (Designat	ed by NUCC)	
			YES	NO.				
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME C	R PROGRAM N	IAME
			YES	NO.)	HMO NAME		
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CODES (De	signated by N	UCC)	d. IS THERE ANOTHER HEALT	H BENEFIT PLA	AN?
						YES X NO	If yes, complete	e items 9, 9a and 9d.
			& SIGNING THIS FORM			13. INSURED'S OR AUTHORIZ		SIGNATURE I authorize igned physician or supplier for
 PATIENT'S OR AUTHORIZED F to process this claim. I also rec 						services described below.	is to the undersi	igned physician of supplier for
below.	E ON EILE					O T CNIA	TIDE ON	DIID
SIGNED	E ON FILE		DATE			SIGNED	URE ON	
14. DATE OF CURRENT ILLNESS	, INJURY, or PREGNAN	` ′	OTHER DATE	1 _I DD _I	YY	16. DATES PATIENT UNABLE MM DD	TO WORK IN CU YY	URRENT OCCUPATION MM DD YY
QUA			JAL.			FROM		0
17. NAME OF REFERRING PROVI	DER OR OTHER SOUP					18. HOSPITALIZATION DATES MM _I DD _I	YY	MM _I DD _I YY
		17b.	NPI			FROM		0
19. ADDITIONAL CLAIM INFORMA	ATION (Designated by N	NUCC)				20. OUTSIDE LAB?	\$	CHARGES
04 DIA ONO 010 OD NATUDE OF I						YES NO		
21. DIAGNOSIS OR NATURE OF I	LLNESS OR INJURY F	Relate A-L to service	e line below (24E)	ICD Ind. 9		22. RESUBMISSION CODE	ORIGINAL RI	EF. NO.
A. L 799.99	в. 🖳	_ C.		D. L		23. PRIOR AUTHORIZATION N	ILIMBER	
E	F	G.		н. L		20. I HIOTI AOTHORIZATION I	IOMBEN	
I. L	J	K.		L	1			1
24. A. DATE(S) OF SERVICE From T	B. PLACE OF		DURES, SERVICES, OR Sin Unusual Circumstances		E. DIAGNOSIS	F. G. DAYS	H. I. S EPSDT ID.	J. RENDERING
MM DD YY MM D	D YY SERVICE I	EMG CPT/HCP	CS MODIF	ÍER	POINTER	\$ CHARGES UNIT		PROVIDER ID. #
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							NPI	
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25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S A	CCOUNT NO 27	ACCEPT ASS	IGNMENT?	28. TOTAL CHARGE	29. AMOUNT P	AID 30. Rsvd for NUCC Use
740001234		20. I AIILINI S F		(For govt. claims,	see back)	\$ 45 00	\$	1
31. SIGNATURE OF PHYSICIAN (DR SUPPLIER	32. SERVICE FA	 CILITY LOCATION INFOR	YES	_INO	33. BILLING PROVIDER INFO		45 00 456-7890
INCLUDING DEGREES OR CF (I certify that the statements or	REDENTIALS		IE HEALTH			ABC HOME HEAL	(-	123/ 130-7070
apply to this bill and are made			ING STREET			123 CARING ST		
SIGNATURE ON FILE			T, TX 77770			ANYTOWN, TX 7		
OLONED	D.1	a. NPI N	DI h			a. NPI	b. 33330	0000
SIGNED	DATE	MET I	O .			NPI	- 22330	UUUA



Home Delivered Meals

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

PICA						PICA TIT
1. MEDICARE MEDICAL		— HFALTH PLAN — BLK LL	OTHER	1a. INSURED'S I.D. NUMBER		(For Program in Item 1)
(Medicare #) (Medicaid		r ID#) (ID#) (ID#)	(ID#)	123456789		
2. PATIENT'S NAME (Last Name, I	First Name, Middle Initial)	MM I DD I YY —	SEX	4. INSURED'S NAME (Last Nam	e, First Name, N	Middle Initial)
DOE, JOHN M. 5. PATIENT'S ADDRESS (No., Stre	204)	01 01 1950 M X		DOE, JOHN M. 7. INSURED'S ADDRESS (No., S	Ctroot)	
* * *	et)		1 -	123 ABC STREET		
123 ABC STREET	OTATE	Self Spouse Child	Other	CITY	L	OTATE
CITY ANYTOWN	STATE	8. RESERVED FOR NUCC USE				STATE
ZIP CODE	TELEPHONE (Include Area Code)	_		ANYTOWN ZIP CODE	TELEBLIONE	(Include Area Code)
	/ \				,	`.
77777	Norma First Norma Middle Initials	40 IO DATIFAITIO CONDITION DEL AT	TD TO:	77777	\	3) 456-7890
9. OTHER INSURED'S NAME (Las	t Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELAT	ED IO:	11. INSURED'S POLICY GROUI	OR FECA NUI	MBER
. OTHER INSURED'S POLICY OF	R GROUP NUMBER	a. EMPLOYMENT? (Current or Previ	one)	a INSURED'S DATE OF BIRTH		SEX
			VO	a. INSURED'S DATE OF BIRTH MM DD YY I	N	и Г F Г
o. RESERVED FOR NUCC USE		b AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated		"
			PLACE (State)	b. OTTEN OB IIIVIB (Bedignated	1 by 11000)	
:. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OF	PROGRAM NA	AME
			10			
				HMO NAME	DELICE TO THE	
d. INSURANCE PLAN NAME OR I	PROGRAM NAME	10d. CLAIM CODES (Designated by N	NUCC)	d. IS THERE ANOTHER HEALTH		
	ACK OF FORM REFORE COMP. T-	A S CIONINO TURO FORES		YES X NO 11 13. INSURED'S OR AUTHORIZE		items 9, 9a and 9d.
2. PATIENT'S OR AUTHORIZED P	ACK OF FORM BEFORE COMPLETING PERSON'S SIGNATURE. I authorize the rele	ease of any medical or other information		payment of medical benefits		ned physician or supplier for
to process this claim. I also req below.	uest payment of government benefits either	er to myself or to the party who accepts	assignment	services described below.		
STGNATURI	E ON FILE			SIGNATU	JRE ON I	FILE
SIGNED	, INJURY, or PREGNANCY (LMP): 15.	OTHER DATE		SIGNED		
MM DD YY		JAL. MM DD	YY	MM DD	YY	MM DD YY
7. NAME OF REFERRING PROVI				FROM	TC RELATED TO CU	
	17b.	-		MM DD FROM	YY TO	MM DD YY
i 9. ADDITIONAL CLAIM INFORMA				20. OUTSIDE LAB?		´ i I CHARGES
	(=g),			YES NO		
1. DIAGNOSIS OR NATURE OF I	LLNESS OR INJURY Relate A-L to service	ce line below (24E) ICD Ind. 9		22. RESUBMISSION		
A 799.99			T.	CODE	ORIGINAL RE	F. NO.
A. [799.99	B. L. C.			23. PRIOR AUTHORIZATION NU	MBER	
E. L.	F G.	L Н. L				
24. A. DATE(S) OF SERVICE	J K. B. C. D. PROCE	EDURES, SERVICES, OR SUPPLIES		F. G. DAYS	H. I.	J.
From T		uin Unusual Circumstances) PCS MODIFIER	DIAGNOSIS POINTER	DAYS OR SCHARGES UNITS	EPSDT ID. Family Plan QUAL.	RENDERING PROVIDER ID. #
NINI DO 11 IVIIVI DI	J TT SERVICE LIVIG CF 1/TICE	WODII ILN	FOINTEN	T TOTANGES UNITS	ZZ	332U00000X
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	-,,					
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5. FEDERAL TAX I.D. NUMBER	SSN EIN 26. PATIENT'S A	ACCOUNT NO. 27. ACCEPT AS		28. TOTAL CHARGE 2	9. AMOUNT PA	30. Rsvd for NUCC Us
740001234		(For govt. claims	NO	\$ 171 36	\$	
1. SIGNATURE OF PHYSICIAN C		CILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO &		23) 456-7890
INCLUDING DEGREES OR CF (I certify that the statements or	n the reverse ABC HOM	ME HEALTH		ABC HOME HEALT		,
apply to this bill and are made	and the second s	RING STREET		123 CARING STR		
SIGNATURE ON FILE	ANYTOWN	I, TX 77770		ANYTOWN, TX 77	770	
SIGNED	DATE a. NPI N	PI b.		a. NPI b	· 332U00	X000X
	DITTE					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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



Minor Home Modification

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

PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
LESS DE LES L'ANDIES DE L'ANDI
(Medicare #) (Medicare #) (ID#) (ID#) (ID#) (ID#) (ID#) 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY MM DD YY DOE, JOHN M. 3. PATIENT'S BIRTH DATE MM DD YY MM X F DOE, JOHN M.
DOE, JOHN M. 01 01 1950 M X F DOE, JOHN M. 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)
123 ABC STREET Self Spouse Child Other 123 ABC STREET CITY STATE 8. RESERVED FOR NUCC USE CITY STATE
ANYTOWN TX ANYTOWN TX
ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code)
77777 (123) 456-7890
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) a. INSURED'S DATE OF BIRTH MM DD YY
YES NO NO F
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC)
YES NO NO
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME
YES NO HMO NAME
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.
SIGNATURE ON FILE SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
GOAL.
, MM, DD, YY MM, DD, YY
17b. NPI FROM TO TO 1 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES
YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION
CODE ORIGINAL REF. NO.
A. 1799.99 B. C. D. D. 23. PRIOR AUTHORIZATION NUMBER
I. L. J. K. L.
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. G. H. I. J.
From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS DAGNOSIS DAGNOSI
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25 FERENLI TAX LD NUMBER SSN FIN 26 PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? 28 TOTAL CHARGE 29 AMOUNT PAID 30 Revel for NUCC
740001234
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (123) 456-7890
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse ABC HOME HEALTH ABC HOME HEALTH
apply to this bill and are made a part thereof.) 123 CARING STREET 123 CARING STREET
SIGNATURE ON FILE ANYTOWN TY 77770 ANYTOWN TY 77770
ANYTOWN, TX 77770 ANYTOWN, TX 77770



Personal Attendant Service

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

(PAS)

PICA				`	,				F	PICA T
1. MEDICARE MEDICAL	D TRICARE	CHAM	PVA GRO	UP FECA LTH PLAN BLK LU	OTHER	1a. INSURED'S I.D. NUMB	ER		(For Program in It	em 1)
(Medicare #) (Medicaid	<u> </u>	(Membe	er ID#) (ID#)	(ID#)	(ID#)	123456789				
2. PATIENT'S NAME (Last Name,	First Name, Middle II	nitial)	3. PATIENT'S E	D I YY —	SEX	4. INSURED'S NAME (Last		Name, M	Middle Initial)	
DOE, JOHN M. 5. PATIENT'S ADDRESS (No., Stre	not)			1 1950 M X		DOE, JOHN M 7. INSURED'S ADDRESS (
123 ABC STREET	36 ()					123 ABC STR				
CITY		STATE		Spouse Child FOR NUCC USE	Other	CITY	11111		ет	ATE
ANYTOWN		TX	6. RESERVED	FOR NUCC USE		ANYTOWN				ΓX
ZIP CODE	TELEPHONE (Inclu					ZIP CODE	TELE	PHONE ((Include Area Code	
77777	()	•				77777	1.222	,	3) 456-789	,
9. OTHER INSURED'S NAME (Las	t Name. First Name.	Middle Initial)	10. IS PATIENT	T'S CONDITION RELAT	TED TO:	11. INSURED'S POLICY G	 ROUP OR FI	`	,	-
(,	,								
a. OTHER INSURED'S POLICY OF	R GROUP NUMBER		a. EMPLOYMI	ENT? (Current or Prev	ious)	a. INSURED'S DATE OF BII	RTH		SEX	
				YES 1	NO		11	M	1 F	:
b. RESERVED FOR NUCC USE			b. AUTO ACC	CIDENT?	PLACE (State)	b. OTHER CLAIM ID (Desig	nated by NL	ICC)		
				YES 1	NO					
c. RESERVED FOR NUCC USE			c. OTHER AC	CIDENT?		c. INSURANCE PLAN NAM	E OR PROG	RAM NA	ME	
				YES 1	NO	HMO NAME				
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CO	ODES (Designated by	NUCC)	d. IS THERE ANOTHER HE	ALTH BENE	FIT PLAN	\ ?	
					-	YES X NO	If yes, c	omplete i	items 9, 9a and 9d.	
	ACK OF FORM BEF					13. INSURED'S OR AUTHO	RIZED PER	SON'S S	IGNATURE I author	rize
PATIENT'S OR AUTHORIZED F to process this claim. I also rec						payment of medical ber services described belo		undersigi	neu physician or su	iphiiet iot
below.	ם ער שונים					G T Char	v mi i o i o	ONT -		
SIGNED	E ON FILE		DATE			SIGNED	ATURE			
I. DATE OF CURRENT ILLNESS MM DD YY	1	1 1	OTHER DATE	MM _I DD _I	YY	16. DATES PATIENT UNAB		K IN CUF	RRENT OCCUPATION OF THE PROPERTY OF THE PROPER	ON YY
QUA NAME OF REFERRING PROVI						FROM 18. HOSPITALIZATION DAT	TEQ DEL ATE	TO		
I NAME OF REFERRING PROVI	DER OR OTHER SO					MM _I DD _I	YY		MM _I DD _I	YY
	ATION (Designated b	17b	. NPI			FROM 20. OUTSIDE LAB?		TO \$ C	HARGES	
1. ADDITIONAL CLAIM INFORM	ATION (Designated b	y NOCC)				YES NO	<u>. I</u>	ΨΟ	 	
1. DIAGNOSIS OR NATURE OF I	LI NESS OR INJURY	' Relate A-L to servi	ce line below (24)	F) 1001 1 0		22. RESUBMISSION	7			
				E) ICD Ind. 9	' i	CODE	ORIG	INAL REF	F. NO.	
A. <u>799.99</u>	В			D. L		23. PRIOR AUTHORIZATIO	N NUMBER			
E. L.	F	G.		H						
1. L	J. B.	K. C. D. PROC		L. L CES, OR SUPPLIES	E.	F.	G. H.	l.	J.	
	o PLACE OI	(Expla	ain Unusual Circu		DIAGNOSIS POINTER	\$ CHARGES	OAYS EPSDT OR Family INITS Plan	ID. QUAL.	RENDERING PROVIDER ID.	
TI IVIIVI D	I I JOLINYICE	TEMMA OF 1/HO		WODILIER	LIGHTEN	ψ OF IANTOLO 0	TATIO FIAI		3747P180	
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5. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S	ACCOUNT NO.	27. ACCEPT AS	SSIGNMENT? is, see back)	28. TOTAL CHARGE		OUNT PAI	- I	or NUCC Us
740001234				YES	NO	\$ 886 4				886 40
31. SIGNATURE OF PHYSICIAN OF INCLUDING DEGREES OR CF				ON INFORMATION		33. BILLING PROVIDER INF		(12	23) 456-7	890
(I certify that the statements o	n the reverse		ME HEALT			ABC HOME HEA				
apply to this bill and are made SIGNATURE ON FILE	a part tileteot.)		RING STR			123 CARING S				
ON TIBE		ANYTYMA	I, TX 77	// U		ANYTOWN, TX	////0			
BIGNED	DATE	a. NPI	b.			a. NPI	b. 37	47P1	801X	



Professional Services

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

PPROVED BY NATIONAL UNIFOR	NIVI CLANVI COMINITI TEE	= (11000) 02/12									
PICA									PICA		
1. MEDICARE MEDICAL		CHAM	PVA GROU	UP FECA TH PLAN BLK LU	ING			(For Progran	m in Item 1)		
(Medicare #) (Medicaid	,	(Membe	er ID#) (ID#)	(ID#)	(ID#)	123456789					
2. PATIENT'S NAME (Last Name, I	First Name, Middle Initi	al)	3. PATIENT'S E	D 1 VV	SEX	4. INSURED'S NAME (Last Na	me, First Name	, Middle Initial)			
DOE, JOHN M. 5. PATIENT'S ADDRESS (No., Stre	not)			1 1950 MX		DOE, JOHN M. 7. INSURED'S ADDRESS (No., Street)					
•	et)					123 ABC STREE					
123 ABC STREET		1		Spouse Child	Other		P.T.		T		
CITY		STATE	8. RESERVED I	FOR NUCC USE		CITY			STATE		
ANYTOWN ZIP CODE	TELEPHONE (Include	TX				ANYTOWN	T		TX		
	/ \	Area Code)				ZIP CODE	,	E (Include Area			
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. OTHER INSURED'S NAME (Las	t Name, First Name, Mi	iddie initial)	IU. IS PATIENT	'S CONDITION RELAT	ED IO:	11. INSURED'S POLICY GRO	UP OR FECA N	UMBER			
. OTHER INSURED'S POLICY OF	R GROUP NUMBER		a EMPLOYM	ENT? (Current or Previ	oue)	a. INSURED'S DATE OF BIRTH	4	SEX			
			a. LIVIPLOTIVII	— ·		MM DD YY	<i>;</i>	м	F 🗍		
o. RESERVED FOR NUCC USE			b. AUTO ACC		10	b. OTHER CLAIM ID (Designat	ed by NILICC)	IVI	' 📙		
			b. A010 A00		PLACE (State)	b. OTTEN OPAINT ID (Designat	ed by NOOO;				
:. RESERVED FOR NUCC USE			c. OTHER AC		.~	c. INSURANCE PLAN NAME O	R PROGRAM N	NAME			
			C. OTHER ACT		10		NOGITAWI I				
						HMO NAME	III DENEET E	ANIO			
I. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CO	DDES (Designated by I	NUCC)	d. IS THERE ANOTHER HEALT			101		
DEAD P	ACK OF FORM BEFOR	DE COMPLETINO	2 & CICNING THI	S EODM		13. INSURED'S OR AUTHORIZ		te items 9, 9a an			
2. PATIENT'S OR AUTHORIZED F to process this claim. I also req below.	ERSON'S SIGNATURE.	. I authorize the rel	ease of any medic	cal or other information		payment of medical benefit services described below.					
SIGNED SIGNATURI	E ON FILE		DATE			SIGNED SIGNAT	URE ON	FILE			
4. DATE OF CURRENT ILLNESS,	INJURY, or PREGNAN	ICY (LMP): 15.	OTHER DATE	MM DD	V V	16. DATES PATIENT UNABLE	TO WORK IN C	URRENT OCCU	IPATION) I YY		
MM DD YY QUA	AL.	Q	UAL.	MM DD	YY	MM DD FROM	YY 1	MM I DE)		
7. NAME OF REFERRING PROVI	DER OR OTHER SOUP	RCE 17a	ı.			18. HOSPITALIZATION DATES	RELATED TO (CURRENT SERV			
		17b	o. NPI			FROM		го			
9. ADDITIONAL CLAIM INFORMA	ATION (Designated by N	NUCC)				20. OUTSIDE LAB?	\$	CHARGES			
						YES NO					
1. DIAGNOSIS OR NATURE OF I	LLNESS OR INJURY F	Relate A-L to servi	ce line below (24	E) ICD Ind. 9		22. RESUBMISSION CODE	ORIGINAL F	REF. NO.			
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E. L	F	_ G.		н. 🖵		23. PRIOR AUTHORIZATION N	IUMBER				
I. L	J	K.		_ L. L_							
24. A. DATE(S) OF SERVICE From T	B. PLACE OF		EDURES, SERVIC	CES, OR SUPPLIES	E. DIAGNOSIS	F. G.	H. I. EPSDT ID.	J. RENDE			
IM DD YY MM DI					POINTER	\$ CHARGES OR UNIT	S Plan QUAL	. PROVIDE	ER ID. #		
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5. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S	ACCOUNT NO	27. ACCEPT AS	SIGNMENT?	28. TOTAL CHARGE	29. AMOUNT F	PAID 30 P	svd for NUCC U		
740001234	JOIN EIIN	20. PATIENT ST	ACCOUNT NO.	(For govt. claim	s, see back)	\$ 3471 20	\$	ן טוי, א	3471 2		
1. SIGNATURE OF PHYSICIAN O	DR SUPPLIER	32. SERVICE FA	ACILITY LOCATIO	YES DN INFORMATION	INO	33. BILLING PROVIDER INFO		123) 456	3471 ₂ 5-7890		
INCLUDING DEGREES OR CF (I certify that the statements or	REDENTIALS		ME HEALTI			ABC HOME HEAL	(-	-20 / 400	, , , , , , ,		
apply to this bill and are made			RING STR			123 CARING ST					
SIGNATURE ON FILE			N, TX 77			ANYTOWN, TX 7					
			b.			a. NDT	h 051 T0	000037			
IGNED	DATE	a. NPI	0.			a. NPI	b. 251J0	AUUUU			