MAYO CLINIC

Understanding Your HCFA 1500 Claim Form

Making sense of Medicare paperwork, including the HCFA 1500 claim form, can be difficult. For that reason, here are some tips and a sample form to assist you. Please note that the lettered items on this page refer to letters printed on the sample form.

A. Printed in the upper left-hand corner of your HCFA 1500 claim form are the name and address of your supplemental insurance company. When you receive your Explanation of Medicare Benefits papers, attach copies to your HCFA 1500 claim forms. Please mail them to the name and address listed here.

B. Please review the insured person's identification number located in Box 1A of this form for accuracy. If this number is different from your records, please contact Mayo Clinic's Patient Account Services at 507-266-5670.

C. The insured person's policy group number is listed in Box 11 of this form. Please verify that this number is correct. If it is blank and you have a policy group number, please write the number in this box.

D. In Box 12, you will see the phrase "Signature on File." This means that you have given Mayo Clinic authorization to release medical information necessary to process your claim.

E. In Box 13, you will see the phrase "Signature on File" which authorizes payment of medical benefits to Mayo Clinic. A blank box indicates that you have not given Mayo Clinic authorization to assign payment of medical benefits.

F. If you were hospitalized at either Rochester Methodist Hospital or Saint Marys Hospital, the dates of hospitalization are listed in Box 18.

G. Please verify that Medicare has processed all charges. To verify charges, compare the date(s) of service (Box 24A), description of service (Box 24D), and the charge for the service (Box 24F) with each line on your Explanation of Medicare Benefits papers.

H. The number in Box 26 is your claim number.

I. Box 27 of this form is called the assignment indicator.

If this box is marked "Yes," Mayo Clinic expects your supplemental insurance company to pay Mayo directly. This does not mean that Mayo will accept the insurance payment as payment in full. You will be responsible for copays, deductibles, non-covered items, and usual and customary allowances.

If this box is marked "No," Mayo Clinic expects your insurance company to pay benefits directly to you.

J. In Box 28, you will find the total charges for that page of the HCFA 1500. If your claim has multiple pages, add the total from each page to figure your total charges for your visit to Mayo Clinic.

For questions about the HCFA 1500 claim form or any other form in the billing process, please call 507-266-5670.

APPROVED OMB-0938-0008

A

HCFA 1500 Sample Form

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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

C

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

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 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.

SIGNED D DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED E

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. 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 FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

F

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

G

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

H

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

I

28. TOTAL CHARGE $

J

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500