Description of Health Insurance Claim Form (HCFA-1500)

**Block 1**
Type(s) of Health Insurance: Indicate coverage applicable to this claim by checking the appropriate box(s).

**Block 1a**
Insured’s I.D. Number: Enter the subscriber’s HMOLA identification number exactly as it appears on the identification card.

**Block 2**
Patient’s Name: Enter the full name of the individual treated.

**Block 3**
Patient’s Birth Date: Indicate the month, day and year. Sex: Place an “X” in the appropriate box.

**Block 4**
Insured’s Name: Enter the name from the identification card except when the insured and the patient are the same; then the word “same” may be entered.

**Block 5**
Patient’s Address: Enter the patient’s complete, current mailing address and phone number.

**Block 6**
Patient’s Relationship to Insured: Place an “X” in the appropriate box. Self: Patient is the subscriber. Spouse: Patient is the subscriber’s spouse. Child: Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other: Patient is the subscriber’s grandchild, adult-sponsored dependent or of relationship not covered previously.

**Block 7**
Insured’s Address: Enter the complete address; street, city, state and zip code of the policyholder. If the patient’s address and the insured’s address are the same, enter “same” in this field.

**Block 8**
Patient Status: Check the appropriate box for the patient’s marital status and whether employed or a student. (Single, married, other; employed, full-time student, part-time student.)
Other Health Insurance Coverage: If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).

Is patient’s condition related to: a. Employment? (current or previous), b. Auto Accident?, c. Other Accident? Check appropriate box if applicable.

Patient’s or Authorized Person’s Signature:
Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or “Signature on File” and date required.
NOTE: “Signature on File” indicates that the signature of the patient is contained in the provider’s records.

Not required. Payment for covered services is made directly to HMOLA providers.

Date Of Current: Enter the date of the first illness, injury or pregnancy.

Same or Similar Illness or Injury: Indicate appropriate date(s).

Dates of Disability: Enter dates, if applicable.

Name of Referring Provider: Enter the referring provider’s complete name, if applicable.

Not required.

For Services Related to Hospitalization: Enter dates of admission to and discharge from hospital.

Not required.

Laboratory Work Performed Outside Your Office: Enter, if applicable.

Diagnosis or Nature of Illness or Injury: Enter the ICD-9 code and/or description of the diagnosis.
Prior Authorization Number: Enter the pre-certification or referral authorization number obtained from HMOLA or the PCP’s five-position referral number for referral services.

A. Date(s) of Service: Enter the from and to date(s) for service(s) rendered.

B. Place of Service: Enter the appropriate place of service code. (See back of form for codes.)

C. Type of Service: Enter the Type of Service code that represents the services rendered.

D. Procedures, Services, or Supplies: Enter the appropriate CPT-4 code. Please ensure your office is using the most current edition of CPT-4 and that you update your codes annually.

E. Diagnosis Code: Enter the numeric code that corresponds with the diagnosis code in block 21 when more than one diagnosis is given.

F. Charges: Enter the total charge for each service rendered. You should bill your usual charge to HMOLA regardless of our allowable charges.

G. Days or Units: Indicate the number of times the procedure was performed or the number of visits the line item charge represents.

H. Not Required.

I. Not Required.

J. Not Required.

K. Each provider’s 10-position provider number should be indicated in this block when billing for multiple providers’ services on the same claim.
Federal Tax I.D. Number: Enter the federal tax identification number to which payment should be reported to the Internal Revenue Service.

Patient’s Account Number: Enter the patient’s account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register only if it is indicated on the claim form.

Accept Assignment: Not applicable; used for government claims only.

Total Charge: Total of all charges in Item F.

Signature of Provider: Provider’s signature required, including degrees and credentials. Rubber stamp is acceptable.

Name and Address of Facility: Required, if services were provided at a facility other than the provider’s office.

Provider’s Name, Address, Provider Number, etc.: Enter complete name, address, telephone number and provider number. **Your 10-position provider number is essential for claims processing purposes and should be indicated in the left hand corner of this block next to PIN#.**