

## COMPLETING THE CMS 1500 FORM FOR BLUECARD

BlueCard requires a CMS 1500 for all professional (non-hospital) claims such as doctor, x-ray, and lab. All in-network Blue Cross/Blue Shield providers should already use the CMS 1500 billing format, however, many non-network providers do not. If a professional claim from a provider who does not bill using a CMS 1500 is submitted to BlueCard it must be submitted together with a completed CMS 1500 so that BlueCard can identify the insured and the group. Do not rely on attaching a copy of your health card to identify yourself: if a professional claim is not submitted on or attached to a completed CMS 1500 form, BlueCard may not recognize who you are.

Complete this form if:

- You are submitting a claim to BlueCard, and the bill that the provider gave you is not on the CMS 1500 format. Attach a copy to the itemized bill every time you submit a claim. In addition, a separate form must be completed for each patient.
- A provider will bill BlueCard for you, but does not use the CMS 1500 format. Give the provider a completed CMS 1500 for each patient and instruct them to always include a copy with their bill.

This form replaces the HCFA 1500, so be sure your provider is using the correct version. If a provider already uses the CMS 1500 format but you are experiencing problems with BlueCard not receiving claims from this provider, be sure the provider is completing sections 1a through 11 per the instructions below, and make corrections as necessary.

### TIPS ON COMPLETING THE CMS 1500

Be sure to complete sections 1a, 2, 3, 4, 6, 7, 8, and 11. All remaining sections may be left blank.

### Example

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>DGA12345678J</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE, JANE</b>						3. PATIENT'S BIRTH DATE MM   DD   YY <b>01   21   60</b>			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE, JOHN</b>			
5. PATIENT'S ADDRESS (No., Street)  CITY  STATE						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) <b>123 MAIN STREET</b>  CITY <b>NEW YORK</b> STATE <b>NY</b>			
ZIP CODE		TELEPHONE (Include Area Code) ( )				8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>  Employed <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>						ZIP CODE <b>10022</b>		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 <b>170199M002</b>			

- Be sure to enter the Participant ID Number in box 1a, including the "DGA" at the beginning and the "J" at the end. **Do not use your social security number.** Be sure the "J" is legible, so it will not be mistaken for a "5".
- In box 11, be sure to enter the Group Number from your medical card, which will end in a 2 or 1.
- Enter the insured's and/or dependent's name exactly as it appears on your medical card. If a dependent child does not have a health card issued in their name, enter the dependent child's name exactly as it is on file with the DGA Health Plan.
- Be sure that your home address is entered exactly as the home address on file with the DGA Health Plan.
- If the insured person is also the patient, be sure to write the full name in both box 2 and box 4. Do not write *self* or *same* instead of your name.

### SUBMITTING CLAIMS TO BLUECARD

Claims go to the Blue Cross/Blue Shield office in the area where the services were rendered. *i.e. John Doe lives in New York but visited a doctor in New Jersey. The claim must be submitted to the Blue Cross/Blue Shield office in New Jersey.*

To find the address of your local Blue Cross/Blue Shield office, please visit our website at [www.dgaplans.org](http://www.dgaplans.org). Under the header *Locate a Network Provider* click on the link *Filing a Medical Claim Page*, then click the link *Professional Claims*, and then click on the state where your provider is located.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BLK LUNG <input type="checkbox"/> (ID) OTHER <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.		
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 _____ 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 _____				
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		

CARRIER

PATIENT AND INSURED INFORMATION

ATTENTION BLUECARD PROCESSOR:

THIS IDENTIFIES THE INSURED AND THE GROUP FOR THE ATTACHED BILL.

PLEASE KEEP THIS TOGETHER WITH THE ATTACHED ITEMIZED BILL.

Thank you.