# HCFA 1500 Claim Form Directions

Required fields on the form are marked "**REQUIRED**".

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Patient Information (blocks 2-8). **REQUIRED**

Box 2 - Last Name, First Name, Middle Initial (if any)
Box 3 - Date of Birth and Sex
Box 4 - Beneficiary Name (if different than the name in block 2)
Box 5 - Patient's Address
Box 6 - Patient's Relationship to Insured (used in conjunction with information on block 9)
Box 7 - Insured Address (used in conjunction with information on block 9)
Box 8 - Patient's Marital and Work Status

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Other insurance information (blocks 9-9d) - This section is completed if the Patient has other insurance. **REQUIRED**

Box 9 - Other Insured's Name. Enter the last name, first name, and middle initial of the enrollee in the other insurance policy
9a - Other Insured's Policy or Group Number
9b - Other Insured's Date of Birth, Sex
9c - Other Insured's Employer's Name
9d - Insurance Plan Name or Program Name

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Patient's Condition (blocks 10a-c) - Is the Patient's condition related to Employment? Auto Accident? Other Accident? **REQUIRED**

Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24.

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Patient Signatures (blocks 12-13) **REQUIRED**

Box 12 - Release of Information: Patient's or Authorized Person's Signature

Box 13 - Assignment of Benefit: Insured or Authorized Person's Signature

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Diagnosis Coding (block 21) **REQUIRED**
Enter the diagnosis code from your itemized statement.
No narrative information is needed in block 21.

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Dates of Service (block 24A) **REQUIRED**

Enter the month, day, and year for each procedure or service using the appropriate six-digit format (e,g,: 010111)

Do not date range services in different months on one detail line. Instead, you must split up the dates, prorating the charges and quantity billed appropriately.

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Place of Service (block 24B) **REQUIRED**

Enter the appropriate place of service code 11 for office. List the name and address of the facility where service was rendered on block 32.

Use the 2 digit code only - do not use abbreviations such as "O" for Office, etc.

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$ Charges (block 24F) **REQUIRED**

Enter the charge for each item.

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Days or Units of Service (block 24G) **REQUIRED**

Enter the number of days or units. When multiple services are provided, enter the actual number provided.

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COB - Coordination of Benefits (block 24J)

Check if the service is covered by another insurance carrier. Please attach an Explanation of Benefits form showing this service was claimed to the other carrier. Note other health coverage information in blocks 9 a-d, 6, and 7.

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Federal Tax ID Number (block 25) Enter Physician's Holistic Health Alliance, LLC Tax ID Number 27-3814441

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Total Charge (block 28)

Enter the total amount of the services you are claiming.

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Amount Paid (block 29) **REQUIRED**

Enter payment amounts paid.

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Signature of Physician or Supplier (block 31) **REQUIRED**

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Name and Address of Facility where services were rendered, if other than Practitioner's Office. (block 32) **REQUIRED**

Please write "SAME".

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Provider Billing Information (block 33) **REQUIRED**

Enter the name, address, zip code and telephone number of the physician for the service. Physicians Holistic Health Alliance, LLC, 53800 Generations Drive, South Bend, IN 46635 574-273-3880.