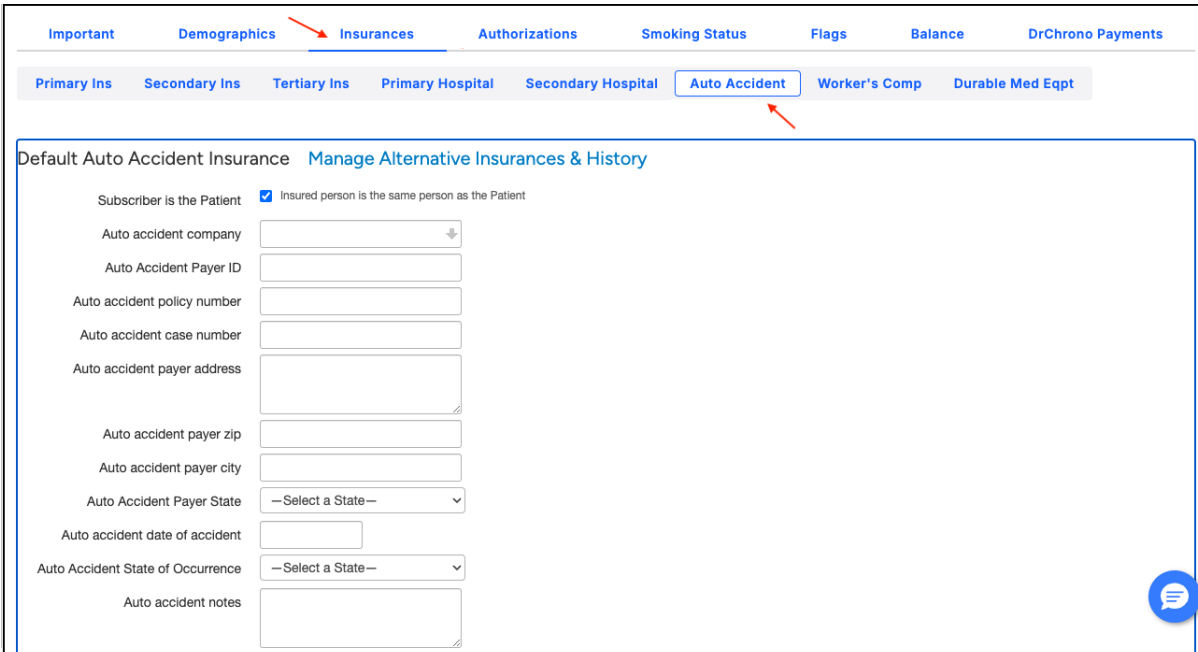


HCFA 1500 Form for Auto Accident Claims

Last modified on 11/22/2024 2:45 pm EST

If you need to complete an HCFA 1500 form for an Auto Accident Claim, follow the simple steps below:

1. Make sure Auto Accident Insurance information is updated by going into the patient's **Clinical Chart > Demographics > Insurances > Auto Accident**



The screenshot displays a web interface for managing insurance information. At the top, there is a navigation bar with tabs: Important, Demographics, Insurances (selected), Authorizations, Smoking Status, Flags, Balance, and DrChrono Payments. Below this, a sub-navigation bar shows: Primary Ins, Secondary Ins, Tertiary Ins, Primary Hospital, Secondary Hospital, Auto Accident (selected), Worker's Comp, and Durable Med Eqpt. The main content area is titled 'Default Auto Accident Insurance' and includes a link for 'Manage Alternative Insurances & History'. The form contains several fields: 'Subscriber is the Patient' (checked), 'Auto accident company' (dropdown), 'Auto Accident Payer ID', 'Auto accident policy number', 'Auto accident case number', 'Auto accident payer address' (text area), 'Auto accident payer zip', 'Auto accident payer city', 'Auto Accident Payer State' (dropdown), 'Auto accident date of accident', 'Auto Accident State of Occurrence' (dropdown), and 'Auto accident notes' (text area). A blue circular icon with a speech bubble is located in the bottom right corner of the form area.

2. From the Appointment Pop-Up you will want to click on **Billing > select correct Billing Status (Auto Accident Claim) > save the changes to the appointment.**

***** Please note, that selecting Auto Accident Claim as the status will send out the claim electronically during the next file pull. *****

3. You can print the HCFA to mail or fax without sending the claim electronically if you choose. Just select or create a separate **custom billing status** (suggestion - Auto Accident Claim Submitted) so that you can keep track of them.

Schedule Appointment

Appointment **Billing** Vitals Revisions Eligibility Flags Custom Data Com. Log MU Helper

Patient SuperBill Clinical Note Billing Details Other Forms

Billing Status **HCFA Box 10 - Is patient's condition related to:**

- Paid In Full
- Balance Due
- Settled
- Internal Review
- Bill Insurance
- Bill Secondary Insurance
- Worker's Comp Claim
- Auto Accident Claim
- Durable Medical Equipment Claim
- Cancelled 24hours

ICD Version

Patient Payment

Payment Notes

Payment Posted Date

Pre Authorization Approval #

Referral #

Payment profile

Billing Profile

Billing Pick List

Diagnosis Pick List

Credit Card Payment

Employment (HCFA Box #14)

Auto Accident (HCFA Box #15)

Other Accident (HCFA Box #19)

Onset Date Type

Onset date

Initial visit date

Last related visit date

ICD-10 Codes

#	Code	Description
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CPT Codes

Code	Description	Price (\$)
------	-------------	------------

ICD-9 Codes to Convert

#	Code	Description
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HCPSC Codes

Code	Description	Price (\$)
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4. Stay in the Appointment Pop-Up and click on **Other Forms** > select **HCFA Form**

Appointment **Billing** Eligibility Vitals Growthcharts Flags Log Comm. Revisions Custom Data MU Helper

Institutional Claim **Other Forms**

Billing Status

ICD Version

Primary Insurer

Secondary Insurer

Patient Payment Copay:

Pre Authorization Approval

Referral #

Payment Profile

Billing Profile

Billing Pick List

Diagnosis Pick List

HCFA Box 10 - Is patient's condition related to:

Employment

Auto Accident

Other Accident

Onset Date Type

Onset Date

Other Date Type

Other Date

HCFA/1500 02/12
HCFA/1500 02/12 (text)
New York: C4.3
New York: NF3

ICD-10 Codes

#	Code	Description
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NDC Codes

NDC Code	Quantity	Units	Line Item
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CPT and HCPSC Codes

Type	Code	Description	Price (\$)
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Custom Codes

Code	Description	Price (\$)
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Include note in EDI Billing:

5. Updated HCFA Form with Auto Accident information entered

HEALTH INSURANCE CLAIM FORM																			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12																			
PICA <input type="checkbox"/>					PICA <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) GFD1234														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Clear, Holly			3. PATIENT'S BIRTH DATE MM DD YY M F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Clear, Holly														
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" 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:		11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M F <input type="checkbox"/>														
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO CA		b. OTHER CLAIM ID (Designated by NUCC)														
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME Auto Club Group														
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.														
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p> <p>SIGNED _____ DATE _____</p>																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL 09 02 14					15. OTHER DATE QUAL MM DD YY														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0																			
22. RESUBMISSION CODE ORIGINAL REF. NO.																			
23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From To		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPST Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1																			
2																			
3																			

All patient data listed in this article is sample data. This is not a real person or real patient data.

6. You can then mail or fax the claim to the auto carrier for consideration and reimbursement.