

HCFA 1500 Form for Auto Accident Claims

Last modified on 01/20/2026 11:19 am 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**

Default Auto Accident Insurance [Manage Alternative Insurances & History](#)

Subscriber is the Patient Insured person is the same person as the Patient

Auto accident company

Auto Accident Payer ID

Auto accident policy number

Auto accident case number

Auto accident payer address

Auto accident payer zip

Auto accident payer city

Auto Accident Payer State

Auto accident date of accident

Auto Accident State of Occurrence

Auto accident notes

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

i *** 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 ▾

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

Employment	No
Auto Accident	No
Other Accident	No

Onset Date Type Onset of Current Symptoms o ▾

Onset date (HCFA Box #14)

Initial visit date (HCFA Box #15)

Last related visit date (HCFA Box #19)

Billing Status ✓

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 Choose Codes from Pick List

Diagnosis Pick List Choose Codes from Pt Problems

Credit Card Payment **Process Credit Card**

ICD-10 Codes Find Diagnosis codes

#	Code	Description
---	------	-------------

CPT Codes Find CPT Procedure codes

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

ICD-9 Codes to Convert Find Diagnosis codes

#	Code	Description
---	------	-------------

HCPCS Codes Find HCPCS Procedure codes

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

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

Patient SuperBill Clinical Note Billing Details **Other Forms ▾** (arrow)

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

Employment	No
Auto Accident	No
Other Accident	No

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

Billing Status

ICD-10

Primary Insurer - Default -

Secondary Insurer - Default -

Patient Payment \$ 0 Copay: \$20 +

Pre Authorization Approval

Referral #

Payment Profile

Billing Profile

Billing Pick List Choose Codes from Pick List

Diagnosis Pick List Choose Codes from Pt Problems

ICD-10 Codes Find Diagnosis codes

#	Code	Description
---	------	-------------

CPT and HCPCS Codes Find CPT/HCPCS codes

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

NDC Codes Find NDC Codes

NDC Code	Quantity	Units	Line Item
----------	----------	-------	-----------

Custom Codes Find Custom Procedure codes

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

Include note in EDI Billing: Custom NTE EDI Billing Note (a.k.a. HCFA/CMS-1500 Line 19)

Delete **Save**

5. Updated HCFA Form with Auto Accident information entered

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																																																																																												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12																																																																																																																																																																																																																																																																																												
<table border="1"> <tr> <td colspan="12">PICA</td> </tr> <tr> <td>1. MEDICARE <input type="checkbox"/> (Medicare #)</td> <td>MEDICAID <input type="checkbox"/> (Medicaid #)</td> <td>TRICARE <input type="checkbox"/> (ID#DOD#)</td> <td>CHAMPVA <input type="checkbox"/> (Member ID#)</td> <td>GROUP HEALTH PLAN <input type="checkbox"/> (ID#)</td> <td>FECA <input type="checkbox"/> (ID#)</td> <td>OTHER <input checked="" type="checkbox"/> (ID#)</td> <td colspan="5">1a. INSURED'S I.O. NUMBER GFD1234</td> <td>PICA <input type="checkbox"/></td> </tr> <tr> <td colspan="3">2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Clear, Holly</td> <td colspan="3">3. PATIENT'S BIRTH DATE MM DD YY</td> <td>SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/></td> <td colspan="5">4. INSURED'S NAME (Last Name, First Name, Middle Initial) Clear, Holly</td> </tr> <tr> <td colspan="3">5. PATIENT'S ADDRESS (No., Street)</td> <td colspan="3">6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></td> <td colspan="5">7. INSURED'S ADDRESS (No., Street)</td> </tr> <tr> <td colspan="2">CITY</td> <td>STATE</td> <td colspan="3">8. RESERVED FOR NUCC USE</td> <td colspan="5">CITY</td> <td>STATE</td> </tr> <tr> <td>ZIP CODE</td> <td colspan="2">TELEPHONE (Include Area Code) ()</td> <td colspan="3">ZIP CODE</td> <td colspan="5">TELEPHONE (Include Area Code) ()</td> </tr> <tr> <td colspan="3">9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td> <td colspan="3">10. IS PATIENT'S CONDITION RELATED TO:</td> <td colspan="5">11. INSURED'S POLICY GROUP OR FECA NUMBER</td> </tr> <tr> <td colspan="3">a. OTHER INSURED'S POLICY OR GROUP NUMBER</td> <td colspan="3">a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td colspan="5">a. INSURED'S DATE OF BIRTH MM DD YY</td> </tr> <tr> <td colspan="3">b. RESERVED FOR NUCC USE</td> <td colspan="3">b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="5">b. OTHER CLAIM ID (Designated by NUCC)</td> </tr> <tr> <td colspan="3">c. RESERVED FOR NUCC USE</td> <td colspan="3">c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td colspan="5">c. INSURANCE PLAN NAME OR PROGRAM NAME Auto Club Group</td> </tr> <tr> <td colspan="3">d. INSURANCE PLAN NAME OR PROGRAM NAME</td> <td colspan="3">10d. CLAIM CODES (Designated by NUCC)</td> <td colspan="5">d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.</td> </tr> <tr> <td colspan="12">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</td> </tr> <tr> <td colspan="12">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.</td> </tr> <tr> <td colspan="3">SIGNED _____ DATE _____</td> <td colspan="3">15. OTHER DATE QUAL. _____ MM DD YY</td> <td colspan="3">16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</td> </tr> <tr> <td colspan="3">14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 09 02 14 QUAL</td> <td colspan="3">17a. _____</td> <td colspan="3">18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</td> </tr> <tr> <td colspan="3">17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____</td> <td colspan="3">17b. _____</td> <td colspan="3">19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td> <td colspan="3">20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="12">21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0</td> </tr> <tr> <td colspan="3">A. _____</td> <td colspan="3">B. _____</td> <td colspan="3">C. _____</td> <td colspan="3">D. _____</td> </tr> <tr> <td colspan="3">E. _____</td> <td colspan="3">F. _____</td> <td colspan="3">G. _____</td> <td colspan="3">H. _____</td> </tr> <tr> <td colspan="3">I. _____</td> <td colspan="3">J. _____</td> <td colspan="3">K. _____</td> <td colspan="3">L. _____</td> </tr> <tr> <td colspan="3">24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</td> <td colspan="3">B. PLACE OF SERVICE EMG</td> <td colspan="3">C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS</td> <td colspan="3">E. DIAGNOSIS MOD/FIER</td> <td>F. \$ CHARGES</td> <td>G. DAYS OF UNITS</td> <td>H. EPOT Family Plan</td> <td>I. ID. #</td> <td>J. RENDERING PROVIDER ID. #</td> </tr> <tr> <td colspan="3">1 _____</td> <td colspan="3">2 _____</td> <td colspan="3">3 _____</td> <td colspan="3">4 _____</td> <td>5 _____</td> <td>6 _____</td> <td>7 _____</td> <td>8 _____</td> </tr> <tr> <td colspan="12">SUPPLIER INFORMATION</td> </tr> </table>												PICA												1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE <input type="checkbox"/> (ID#DOD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.O. NUMBER GFD1234					PICA <input type="checkbox"/>	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Clear, Holly			3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Clear, Holly					5. PATIENT'S ADDRESS (No., Street)			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	8. RESERVED FOR NUCC USE			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					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					b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			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.					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 _____ DATE _____			15. OTHER DATE QUAL. _____ MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 09 02 14 QUAL			17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____			17b. _____			19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0												A. _____			B. _____			C. _____			D. _____			E. _____			F. _____			G. _____			H. _____			I. _____			J. _____			K. _____			L. _____			24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS MOD/FIER			F. \$ CHARGES	G. DAYS OF UNITS	H. EPOT Family Plan	I. ID. #	J. RENDERING PROVIDER ID. #	1 _____			2 _____			3 _____			4 _____			5 _____	6 _____	7 _____	8 _____	SUPPLIER INFORMATION											
PICA																																																																																																																																																																																																																																																																																												
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE <input type="checkbox"/> (ID#DOD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.O. NUMBER GFD1234					PICA <input type="checkbox"/>																																																																																																																																																																																																																																																																																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Clear, Holly			3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Clear, Holly																																																																																																																																																																																																																																																																																					
5. PATIENT'S ADDRESS (No., Street)			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	8. RESERVED FOR NUCC USE			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																																																																																																																																																																																																																																																																																						
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																																																																																																																																																																																																																																																																																						
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			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.																																																																																																																																																																																																																																																																																						
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 _____ DATE _____			15. OTHER DATE QUAL. _____ MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 09 02 14 QUAL			17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____			17b. _____			19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0																																																																																																																																																																																																																																																																																												
A. _____			B. _____			C. _____			D. _____																																																																																																																																																																																																																																																																																			
E. _____			F. _____			G. _____			H. _____																																																																																																																																																																																																																																																																																			
I. _____			J. _____			K. _____			L. _____																																																																																																																																																																																																																																																																																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS MOD/FIER			F. \$ CHARGES	G. DAYS OF UNITS	H. EPOT Family Plan	I. ID. #	J. RENDERING PROVIDER ID. #																																																																																																																																																																																																																																																																												
1 _____			2 _____			3 _____			4 _____			5 _____	6 _____	7 _____	8 _____																																																																																																																																																																																																																																																																													
SUPPLIER INFORMATION																																																																																																																																																																																																																																																																																												

| CARRIER | | | | | | | | | | | |

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.