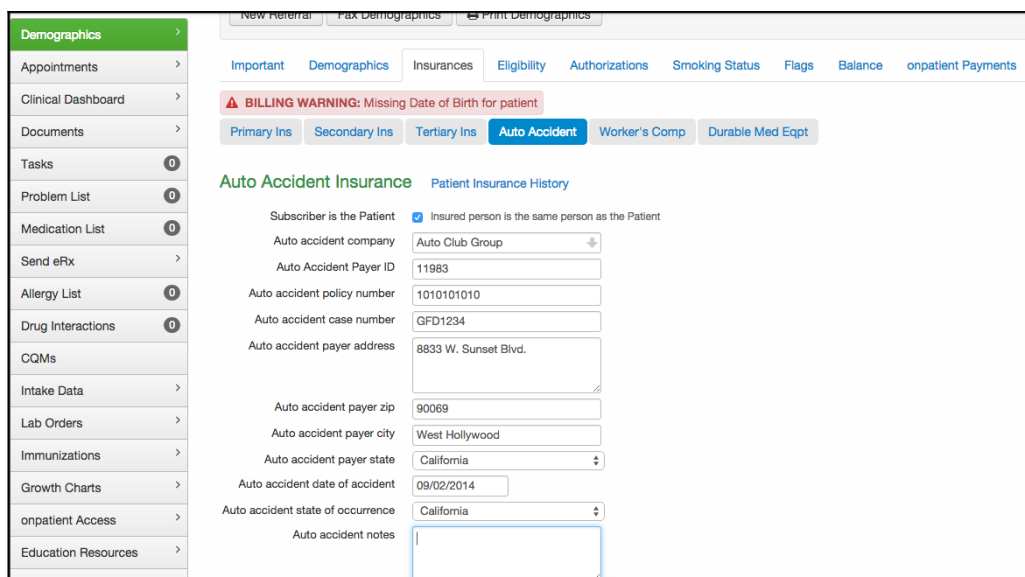


HCFA 1500 Form for Auto Accident Claims

09/16/2024 11:23 am EDT

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** > click on **Demographics** > **Insurances** > **Auto Accident**



The screenshot shows a web-based form for "Auto Accident Insurance". On the left is a navigation menu with "Demographics" selected. The main content area has tabs for "Important", "Demographics", "Insurances", "Eligibility", "Authorizations", "Smoking Status", "Flags", "Balance", and "onpatient Payments". Under "Insurances", there are sub-tabs for "Primary Ins", "Secondary Ins", "Tertiary Ins", "Auto Accident" (which is active), "Worker's Comp", and "Durable Med Eqpt". A red warning banner states: "BILLING WARNING: Missing Date of Birth for patient". Below this, there are two radio buttons: "Subscriber is the Patient" (unchecked) and "Insured person is the same person as the Patient" (checked). The form fields include: "Auto accident company" (Auto Club Group), "Auto Accident Payer ID" (11983), "Auto accident policy number" (1010101010), "Auto accident case number" (GFD1234), "Auto accident payer address" (8833 W. Sunset Blvd.), "Auto accident payer zip" (90069), "Auto accident payer city" (West Hollywood), "Auto accident payer state" (California), "Auto accident date of accident" (09/02/2014), "Auto accident state of occurrence" (California), and "Auto accident notes" (empty text 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**

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

Employment

Auto Accident

Other Accident

Onset Date Type

Onset date (HCFA Box #14)

Initial visit date (HCFA Box #15)

Last related visit date (HCFA Box #19)

ICD-10 Codes

#	Code	Description

ICD-9 Codes to Convert

#	Code	Description

CPT Codes

Code	Description	Price (\$)

HCPCS Codes

Code	Description	Price (\$)

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

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

- 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

4. Stay in the Appointment Pop-Up and click on **Other Form** > select **HCFA Form**

Schedule Appointment

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

Patient SuperBill Clinical Note Billing Details Other Forms

Billing Status Auto Accident Claim **HCFA Box 10 - Is patient's condition related to an injury?** HCFA/1500 02/12

ICD Version ICD-10 Employment No HCFA/1500 02/12 (text)

Patient Payment 0.00 Auto Accident No New York: C4.3

Payment Notes Other Accident No New York: NF3

Payment Posted Date 02/16/2016 Onset Date Type Onset of Current Illness

Pre Authorization Approval # Onset date (HCFA Box #14)

Referral # Initial visit date (HCFA Box #15)

Payment profile Last related visit date (HCFA Box #19)

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
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CPT Codes Find CPT Procedure codes

Code	Description	Price (\$)
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ICD-9 Codes to Convert Find Diagnosis codes

#	Code	Description
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HCPCS Codes Find HCPCS Procedure codes

Code	Description	Price (\$)
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5. Updated HCFA Form with Auto Accident information entered

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA												
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 SEX 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) ()		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			b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME Auto Club Group			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 8a and 9d.</i>											
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, 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					17a. _____ 17b. NPI					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		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.										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY					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. EPDT Entry 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.