

# HCFA 1500 Form for Auto Accident Claims

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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 the HCFA 1500 form interface. At the top, there are tabs for 'Important', 'Demographics', 'Insurances', 'Authorizations', 'Smoking Status', 'Flags', 'Balance', and 'DrChrono Payments'. The 'Insurances' tab is selected, and within it, the 'Auto Accident' sub-tab is highlighted. Below the tabs, there are fields for 'Primary Ins', 'Secondary Ins', 'Tertiary Ins', 'Primary Hospital', 'Secondary Hospital', 'Auto Accident', 'Worker's Comp', and 'Durable Med Eqpt'. The 'Auto Accident' field is active, showing a form with the following fields: 'Subscriber is the Patient' (checked), 'Insured person is the same person as the Patient' (checked), 'Auto accident company' (dropdown), 'Auto Accident Payer ID' (text), 'Auto accident policy number' (text), 'Auto accident case number' (text), 'Auto accident payer address' (text), 'Auto accident payer zip' (text), 'Auto accident payer city' (text), 'Auto Accident Payer State' (dropdown), 'Auto accident date of accident' (text), 'Auto Accident State of Occurrence' (dropdown), and 'Auto accident notes' (text). A blue chat icon is visible in the bottom right corner.

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
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

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

Employment
Auto Accident
Other Accident

Onset Date Type
Onset date
Initial visit date
Last related visit date

ICD-10 Codes
Find Diagnosis codes

CPT Codes
Find CPT Procedure codes

ICD-9 Codes to Convert
Find Diagnosis codes

HCPCS Codes
Find HCPCS Procedure codes

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

Billing Status
ICD Version
Primary Insurer
Secondary Insurer
Patient Payment
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

ICD-10 Codes
Find Diagnosis codes

CPT and HCPCS Codes
Find CPT/HCPCS codes

NDC Codes
Find NDC Codes

Custom Codes
Find Custom Procedure codes

☐ 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										PICA	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
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 checked="" type="checkbox"/> OTHER <input type="checkbox"/>										PICA	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Clear, Holly</b>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>GFD1234</b>	
3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> SEX										4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Clear, Holly</b>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										7. INSURED'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"/>										8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <b>CA</b>	
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME										11. INSURED'S POLICY GROUP OR FECA NUMBER	
10d. CLAIM CODES (Designated by NUCC)										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										b. OTHER CLAIM ID (Designated by NUCC)	
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.										c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Auto Club Group</b>	
SIGNED _____ DATE _____										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
15. OTHER DATE QUAL MM DD YY										SIGNED _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. NPI										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? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ 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.	
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER	
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. EPSDT Family Plan? I. ID. QUAL J. RENDERING PROVIDER ID. #											
1										NPI	
2										NPI	
3										NPI	

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.