How to Complete the HCFA 1500 Claim Form for Out-of-Network Outpatient Providers

The following information is provided in order to properly complete the *TOP PORTION* of the claim form.

TOP HALF OF FORM

Box 1	Place an "X" in the box labeled Group Health Plan.
Box 1a	**Enter the Social Security Number of the employee/policyholder.**
Box 2	Enter the patient's name.
Box 3	Enter the date of birth of the patient.
Box 4	Enter the name of the employee/policyholder.
Box 5	Enter the address (physical or mailing, whichever you prefer) of the patient. (In the boxes directly under box 5, enter the city, state, zip code and telephone number of the patient.)
Box 6	Place an "X" in the box that identifies the relationship of the patient to the policyholder.
Box 7	Enter the mailing address of the employee/policyholder. (In the boxes directly under Box 7, enter the city, state, zip code and telephone number of the employee/policyholder.)
Box 8	Enter the patient's marital and employment status.
Box 9	Enter the name of any other person that also covers the patient under their insurance plan. (e.g., If a child is covered by both parents' insurance plans, the UC parent would be listed in Box 4, and the second parent would be listed in Box 9.) If there is no other insurance, enter "NONE".
Box (9)a	Enter the policy/group number of the other insurance plan that covers the patient.
Box (9)b	Enter the date of birth and gender of the person that covers the patient under another insurance plan. If there is no other insurance, enter "NONE".
Box (9)c	Enter the name of the employer of the person that covers the patient under another plan. If there is no other insurance, enter "NONE".
Box (9)d	Enter the name of the Insurance Plan or Program Name of the other insurance plan. If there is no other insurance, enter "NONE".
Box 10	Place an "X" in the appropriate boxes to answer the questions about the patient's condition.
Box 10d	Leave blank.
Box 11	**Enter University of California's Optum policy number: 11280.**
Box 11a	Enter the date of birth and gender of the employee/policyholder.
Box 11b	**Enter "UNIVERSITY OF CALIFORNIA". (You may identify the campus as well.)**
Box 11c	**Enter "OPTUM".**
Box 11d	Place an "X" in the appropriate box to indicate if patient is also covered under another health plan. **Do not leave this box blank.**
Box 12	Sign **ONLY** if the policyholder is to receive payment.*
Box 13	Sign **ONLY** if the provider is to receive payment.*
	Do not sign both Boxes 12 AND 13; sign Box 12 **OR** Box 13.**

At this point, you can attach statements and/or receipts from the provider in lieu of completing the remainder of the claim form. However, all of the following information must be on the statements/receipts. Please indicate on the statements/receipts if the bill has been "paid in full".

1. Policyholder's name.
2. Patient's name.
3. Employee Social Security Number.
4. Clinician's name, address, phone, licensure type, and tax id number.
5. Diagnosis code.
6. Date(s) of service, CPT code(s), and length of session(s).
7. Amount charged.

The following information is to assist in completing the *BOTTOM PORTION* of the claim form.

BOTTOM HALF OF FORM

Box 14 – 20 You may leave **Boxes 14 through 20** blank.

Box 21 Enter the diagnosis code (DSM code). If it not present on the receipt/bill, call your provider to get the code.

Box 22 Enter "NA". This box is not applicable.

Box 23 If your plan requires preauthorization for treatment, then enter the number here.

Box 24 In **Column A**, enter each date of service under the "From" section. There is no need to enter a date in the "To" section because outpatient sessions do not last more than 24 hours. If the session was in an office, then enter "11" (eleven) in **Column B**. You may leave **Column C** blank. In **Column D**, enter the CPT code for each corresponding date of service. (You may get this information from the provider if it is not noted on the bill/receipt.) You may leave the Modifier section in Column D blank. **Column E** may be left blank if you have filled in the diagnosis code in Box 21; enter diagnosis code here only if different from diagnosis code in Box 21. In **Column F**, enter the amount charged for the corresponding date of service. **Columns G, H, I, J, and K** may be left blank.

Box 25 Enter the Federal Tax ID of the provider. Be sure to mark if the number is the SSN or the EIN (employer ID number).

Box 26 Providers use this box to easily identify patient accounts. You may leave this box blank.

Box 27 Leave blank.

Box 28 Enter the total of charges listed on the claim form.

Box 29 Enter the amount patient paid toward charges listed on the claim form.

Box 30 Enter the balance due to the provider for charges listed on this claim form.

Box 31 Signature of the provider if you provide receipts/bills, however, you will need to enter the date the form was completed.

Box 32 Enter the Name of Clinician/Clinic and address where services were rendered.

Box 33 Enter the billing name of the clinician, address, and phone number. (This information may be a replication of Box 32.)

If you have questions concerning the claim form that this tips sheet did not address, please call Customer Service at 1-888-440-UCAL (8225).

TIPS:

1. **The claim form PDF on liveandworkwell.com is very large, so you may need to adjust the quality of the document in order to print the form without errors. In order to do this, click on "File" in the upper left corner of the new window and then select Print. When the Print box appears, select Properties and then click on the "Advanced" button in the lower right corner. Click on "Graphic" and change the print quality to a lower value, such as "300 x 300". Click OK until you get back to the Print Box. Click on the "OK" button to print the document.**

2. **Fill out the top half of the form and make photocopies for future use. Fill out and submit bottom half as needed.**

3. **It is good practice to keep copies of any claims documents for your records.**

4. **Once the claim has been filled out please mail it and any necessary supporting documentation to the following address.**

Claims should be mailed to the following address:

Optum Claims
PO BOX 30760
Salt Lake City, UT 84130-0760