# CLAIMS RESOURCE SUPPLEMENT

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# CLAIMS RESOURCE SUPPLEMENT

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# Patient Information

On the following pages are patient information forms. They will be used to provide the necessary information for the claim forms that you will be completing throughout your training. Read over each patient information form now. For your convenience in completing the exercises and quizzes, this information is included in alphabetical order.

**PATIENT INFORMATION**

Please complete this form.

NAME: **Kristy Arnold**

ADDRESS: **3519 Habit Rd**
**Youngstown, CO 80001**

HOME PHONE: **970-555-8838**

WORK PHONE: ____________

DATE OF BIRTH: **April 7, 2001** AGE: ________

SEX: Male ________ Female **X**

MARITAL STATUS: Married ________ Single **X**
Separated ________ Divorced ________
Widowed ________

PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Barbara Arnold 970-555-8838**

EMPLOYED: Full Time ________ Part Time ________
Retired ________ Not Employed ________

EMPLOYER: ____________

COMPANY ADDRESS: ____________

PHONE: ____________

STUDENT STATUS: Full Time **X**
Part Time ________

INSURANCE COMPANY: **Blue Cross of OH**

Insured's ID: **811000924**

Group Number: **J620**

Address: **3737 Sylvania Avenue**
**Toledo, OH 43623 4422**

Name of Insured: **Barbara Arnold**

Date of Birth: **January 10, 1979**

Employer: **Governor Co**

Patient's Relationship to Insured: **child**

OTHER INSURANCE: **Country Group**

Insured's ID: **73055**

Group Number: **210B**

Address: **PO Box 37**
**Toledo, OH 43623**

Name of Insured: **Bill Arnold**

Date of Birth: **December 23, 1965**

Employer: **Star Construction**

Patient's Relationship to Insured: **child**

**PATIENT INFORMATION**

Please complete this form.

NAME: Rebecca Bloomquist

ADDRESS: 409 Yorkshire
Yourtown, CO 80001

HOME PHONE: 970-555-5875

WORK PHONE: ____

DATE OF BIRTH: June 25, 1997 AGE: ____

SEX: Male ____ Female X

MARITAL STATUS: Married ____ Single X
Separated ____ Divorced ____
Widowed ____

PERSON TO CONTACT IN EMERGENCY AND PHONE:

____

EMPLOYED: Full Time ____ Part Time ____
Retired ____ Not Employed ____

EMPLOYER: ____

COMPANY ADDRESS: ____

PHONE: ____

STUDENT STATUS: Full Time X
Part Time ____

INSURANCE COMPANY: Med Link HMO

Insured's ID: 521 00 900602

Group Number: WBHMO

Address: PO Box 560
Yourtown, CO 80001

Name of Insured: Dick Bloomquist

Date of Birth: March 10, 1967

Employer: Wilton Bookstore

Patient's Relationship to Insured: child

OTHER INSURANCE: ____

Insured's ID: ____

Group Number: ____

Address: ____

Name of Insured: ____

Date of Birth: ____

Employer: ____

Patient's Relationship to Insured: ____



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**PATIENT INFORMATION**

Please complete this form.
NAME: **Joe Burton**
ADDRESS: **6243 Hickory Lane**
**Mytown, CO 80001**
HOME PHONE: **970-555-2221**
WORK PHONE: ____________
DATE OF BIRTH: **November 27, 1961** AGE: ____________
SEX: Male **X** Female ________
MARITAL STATUS: Married ________ Single **X**
Separated ________ Divorced ________
Widowed ________
PERSON TO CONTACT IN EMERGENCY AND PHONE:
____________
EMPLOYED: Full Time ________ Part Time **X**
Retired ________ Not Employed ________

EMPLOYER: **Warehouse Plus**
COMPANY ADDRESS: **4848 West Street**
**Mytown, CO 80001**
PHONE: **(970) 555-8899**
STUDENT STATUS: Full Time ________
Part Time ________
INSURANCE COMPANY: ____________
Insured's ID: **623-00-3864**
Group Number: ____________
Address: ____________

Name of Insured: ____________
Date of Birth: ____________
Employer: ____________
Patient's Relationship to Insured: ____________

OTHER INSURANCE: ____________
Insured's ID: ____________
Group Number: ____________
Address: ____________

Name of Insured: ____________
Date of Birth: ____________
Employer: ____________
Patient's Relationship to Insured: ____________

**PATIENT INFORMATION**

Please complete this form.
NAME: **Andy Cavello**
ADDRESS: **883 Claybasket Circle**
**Anytown, CO 80001**
HOME PHONE: **970-555-8812**
WORK PHONE: ____________
DATE OF BIRTH: **January 15, 1997** AGE: ____________
SEX: Male **X** Female ______
MARITAL STATUS: Married ______ Single **X**
Separated ______ Divorced ______
Widowed ______
PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Cecelia Cavello 970-555-8812**
EMPLOYED: Full Time ______ Part Time ______
Retired ______ Not Employed ______

EMPLOYER: ____________
COMPANY ADDRESS: ____________

PHONE: ____________
STUDENT STATUS: Full Time **X**
Part Time ______
INSURANCE COMPANY: **Blue Cross of CO**
Insured's ID: **630-00-0099A**
Group Number: **BM630**
Address: **PO Box 76**
**Denver, CO 80217**

Name of Insured: **Mark Cavello**
Date of Birth: **July 6, 1968**
Employer: **Beaver Market**
Patient's Relationship to Insured: **child**

OTHER INSURANCE: **Cigna**
Insured's ID: **119001031**
Group Number: **488C**
Address: **1212 Drake**
**Yourtown, OH 01012**
Name of Insured: **Cecelia Cavello**
Date of Birth: **October 9, 1970**
Employer: **Advanced Engineering**
Patient's Relationship to Insured: **child**


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**PATIENT INFORMATION**

Please complete this form.
NAME: **Wally Cricket**
ADDRESS: **2227 Garden Court**
**Anytown, CO 80000**
HOME PHONE: **970-555-9898**
WORK PHONE: **970-555-2376**
DATE OF BIRTH: **07-07-61** AGE: ____
SEX: Male **X** Female ____
MARITAL STATUS: Married ____ Single **X**
Separated ____ Divorced ____
Widowed ____
PERSON TO CONTACT IN EMERGENCY AND PHONE:
____
EMPLOYED: Full Time **X** Part Time ____
Retired ____ Not Employed ____

EMPLOYER: **Cabinets and More**
COMPANY ADDRESS: **2000 Market Street**
**Anytown, CO 80000**
PHONE: **970-555-2376**
STUDENT STATUS: Full Time ____
Part Time ____
INSURANCE COMPANY: **None**
Insured's ID: ____
Group Number: ____
Address: ____
____

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

OTHER INSURANCE: ____
Insured's ID: ____
Group Number: ____
Address: ____
____

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

**PATIENT INFORMATION**

Please complete this form.
NAME: Erin Falls
ADDRESS: 3892 Cloud Dr.
Fort Collins, CO 80526
HOME PHONE: (970) 555-9870
WORK PHONE: ________
DATE OF BIRTH: 4-18-2001 AGE: ________
SEX: Male ________ Female X
MARITAL STATUS: Married ________ Single X
Separated ________ Divorced ________
Widowed ________
PERSON TO CONTACT IN EMERGENCY AND PHONE:
________
EMPLOYED: Full Time ________ Part Time ________
Retired ________ Not Employed ________

EMPLOYER: ________
COMPANY ADDRESS: ________
________
PHONE: ________
STUDENT STATUS: Full Time X
Part Time ________
INSURANCE COMPANY: FHP
Insured's ID: 111-32-4587
Group Number: 310
Address: 2020 Davidson Dr.
Denver CO 80020

Name of Insured: George Falls (signature on file)
Date of Birth: 02-27-1969
Employer: Mountain Market
Patient's Relationship to Insured: child

OTHER INSURANCE: Mountain States
Insured's ID: 222-03-1111
Group Number: 418
Address: 1801 SW Vine Street
Denver CO 80217
Name of Insured: Susan Falls (signature on file)
Date of Birth: 10-04-1971
Employer: Alpine Media
Patient's Relationship to Insured: child



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**PATIENT INFORMATION**

Please complete this form.
NAME: **Benjamin Fox**
ADDRESS: **1227 Comet Drive Apt 6B**
**Springtown, CO 80002**
HOME PHONE: **970-555-1001**
WORK PHONE: **970-555-2913**
DATE OF BIRTH: **December 2, 1970** AGE: ______
SEX: Male **X** Female ______
MARITAL STATUS: Married ______ Single **X**
Separated ______ Divorced ______
Widowed ______
PERSON TO CONTACT IN EMERGENCY AND PHONE:
______
EMPLOYED: Full Time **X** Part Time ______
Retired ______ Not Employed ______

EMPLOYER: **Philco Gas**
COMPANY ADDRESS: **983 North Avenue**
**Springtown, CO 80002**
PHONE: **970-555-2913**
STUDENT STATUS: Full Time ______
Part Time **X**
INSURANCE COMPANY: **Mountain States**
Insured's ID: **520-00-7777**
Group Number: **120**
Address: **1801 SW Vine Street**
**Denver, CO 80217**

Name of Insured: ______
Date of Birth: ______
Employer: ______
Patient's Relationship to Insured: ______

OTHER INSURANCE: ______
Insured's ID: ______
Group Number: ______
Address: ______
______

Name of Insured: ______
Date of Birth: ______
Employer: ______
Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.
NAME: **Steven Gibbs**
ADDRESS: **1343 Oval St.**
**Windsor, CO 80520**
HOME PHONE: **970-555-7643**
WORK PHONE: ______
DATE OF BIRTH: **08-10-2000** AGE: ______
SEX: Male **X** Female ______
MARITAL STATUS: Married ______ Single **X**
Separated ______ Divorced ______
Widowed ______
PERSON TO CONTACT IN EMERGENCY AND PHONE:
______
EMPLOYED: Full Time ______ Part Time ______
Retired ______ Not Employed ______

EMPLOYER: ______
COMPANY ADDRESS: ______
______
PHONE: ______
STUDENT STATUS: Full Time **X**
Part Time ______
INSURANCE COMPANY: **Mountain States**
Insured's ID: **012-34-5678**
Group Number: **420**
Address: **1801 SW Vine Street**
**Denver, CO 80217**

Name of Insured: **Michael Gibbs**
Date of Birth: **2-11-1969**
Employer: **Advanced Communications**
Patient's Relationship
to Insured: **child**

OTHER INSURANCE: ______
Insured's ID: ______
Group Number: ______
Address: ______
______

Name of Insured: ______
Date of Birth: ______
Employer: ______
Patient's Relationship
to Insured: ______



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**PATIENT INFORMATION**

Please complete this form.

NAME: Cathy Harrison

ADDRESS: 2419 Zendt Drive
Anytown, CO 80000

HOME PHONE: 970-555-2112

WORK PHONE: 970-555-1397

DATE OF BIRTH: August 9, 1967 AGE: ______

SEX: Male ______ Female X

MARITAL STATUS: Married X Single ______
Separated ______ Divorced ______
Widowed ______

PERSON TO CONTACT IN EMERGENCY AND PHONE:
Tom Harrison 970-555-4873

EMPLOYED: Full Time ______ Part Time X
Retired ______ Not Employed ______

EMPLOYER: Sandy's Nails

COMPANY ADDRESS: 452 Link Lane
Anytown, CO 80000

PHONE: 970-555-1397

STUDENT STATUS: Full Time ______
Part Time ______

INSURANCE COMPANY: Blue Cross of Wyoming

Insured's ID: 641000000

Group Number: GE54002

Address: PO Box 456
Casper, WY 82002

Name of Insured: Tom Harrison

Date of Birth: 08-02-59

Employer: Front Range Auto Sales

Patient's Relationship to Insured: spouse

OTHER INSURANCE: ______

Insured's ID: ______

Group Number: ______

Address: ______

Name of Insured: ______

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.

NAME: Paula Higgins

ADDRESS: 2159 Wyndote Street
Yourtown, CO 80000

HOME PHONE: 970-555-1839

WORK PHONE: 970-555-1613

DATE OF BIRTH: October 18, 1976 AGE: ______

SEX: Male ______ Female X

MARITAL STATUS: Married ______ Single X
Separated ______ Divorced ______
Widowed ______

PERSON TO CONTACT IN EMERGENCY AND PHONE:

______

EMPLOYED: Full Time X Part Time ______
Retired ______ Not Employed ______

EMPLOYER: ______

COMPANY ADDRESS: Dinger's Pancake House
1340 Main Street
Yourtown, CO 80000

PHONE: ______

STUDENT STATUS: Full Time ______
Part Time ______

INSURANCE COMPANY: ______

Insured's ID: None

Group Number: ______

Address: ______

Name of Insured: ______

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

OTHER INSURANCE: ______

Insured's ID: ______

Group Number: ______

Address: ______

Name of Insured: ______

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______



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**PATIENT INFORMATION**

Please complete this form.

NAME: **Samuel Jones**

ADDRESS: **3 Hwy South**
**Anytown, CO 80000**

HOME PHONE: **970-555-1313**

WORK PHONE: **970-555-2902**

DATE OF BIRTH: **May 19, 1972** AGE: ______

SEX: Male **X** Female ______

MARITAL STATUS: Married ______ Single ______
Separated ______ Divorced **X**
Widowed ______

PERSON TO CONTACT IN EMERGENCY AND PHONE:

______

EMPLOYED: Full Time **X** Part Time ______
Retired ______ Not Employed ______

EMPLOYER: **Green Finger Nursery**

COMPANY ADDRESS: **212 Timberline Road**
**Anytown, CO 80000**

PHONE: **970-555-2902**

STUDENT STATUS: Full Time **X**
Part Time ______

INSURANCE COMPANY: **Blue Cross of IA**

Insured's ID: **666 00 6663**

Group Number: **VE001**

Address: **PO Box 1677**
**Sioux City, IA 51102**

Name of Insured: ______

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

OTHER INSURANCE: ______

Insured's ID: ______

Group Number: ______

Address: ______

______

Name of Insured: ______

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.
NAME: **Tommy Kelly**
ADDRESS: **3721 Huckle Avenue**
**Yourtown, CO 80000**
HOME PHONE: **970-555-2456**
WORK PHONE: ____
DATE OF BIRTH: **March 17, 1995** AGE: ____
SEX: Male **X** Female ____
MARITAL STATUS: Married ____ Single **X**
Separated ____ Divorced ____
Widowed ____
PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Carol Kelly 970-555-2121**
EMPLOYED: Full Time ____ Part Time ____
Retired ____ Not Employed ____

EMPLOYER: ____
COMPANY ADDRESS: ____

PHONE: ____
STUDENT STATUS: Full Time **X**
Part Time ____
INSURANCE COMPANY: **Preferred Coverage**
Insured's ID: **375000006**
Group Number: **320**
Address: **729 Clayton Drive**
**Yourtown, CO 80000**

Name of Insured: **Carol Kelly**
Date of Birth: **January 30, 1961**
Employer: **Red Rocks School**
Patient's Relationship
to Insured: **child**

OTHER INSURANCE: **Cigna**
Insured's ID: **402002001**
Group Number: **H480**
Address: **PO Box 675**
**Yourtown, CO 80000**
Name of Insured: **Robert Kelly**
Date of Birth: **July 7, 1962**
Employer: **Mountain Brewery**
Patient's Relationship
to Insured: **child**

**PATIENT INFORMATION**

Please complete this form.

NAME: **Fran Mac**

ADDRESS: **1823 Kerry Court**
**Yourtown, CO 80000**

HOME PHONE: **970-555-2210**

WORK PHONE: ______

DATE OF BIRTH: **08-13-60** AGE: ______

SEX: Male ______ Female **X**

MARITAL STATUS: Married **X** Single ______
Separated ______ Divorced ______
Widowed ______

PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Steve Mac 970-555-2210**

EMPLOYED: Full Time ______ Part Time ______
Retired ______ Not Employed **X**

EMPLOYER: ______

COMPANY ADDRESS: ______

PHONE: ______

STUDENT STATUS: Full Time ______
Part Time ______

INSURANCE COMPANY: **Blue Cross of CO**

Insured's ID: **605 00 0508**

Group Number: **A5880**

Address: **PO Box 8000**
**Anytown, CO 80000**

Name of Insured: **Steve Mac (signature on file)**

Date of Birth: **07-13-60**

Employer: **Steel Recycling**

Patient's Relationship to Insured: **spouse**

OTHER INSURANCE: ______

Insured's ID: ______

Group Number: ______

Address: ______

Name of Insured: ______

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.
NAME: Vicki McGuire
ADDRESS: 1210 Harris St Apt 9J
Springtown, CO 80002
HOME PHONE: 970-555-3799
WORK PHONE: ____
DATE OF BIRTH: May 5, 1993 AGE: ____
SEX: Male ____ Female X
MARITAL STATUS: Married ____ Single X
Separated ____ Divorced ____
Widowed ____
PERSON TO CONTACT IN EMERGENCY AND PHONE:
Julie McGuire 970-555-3799
EMPLOYED: Full Time ____ Part Time ____
Retired ____ Not Employed ____

EMPLOYER: ____
COMPANY ADDRESS: ____

PHONE: ____
STUDENT STATUS: Full Time X
Part Time ____
INSURANCE COMPANY: Medicaid
Insured's ID: 721-00-5553
Group Number: ____
Address: PO Box 1461
Denver, CO 80203

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

OTHER INSURANCE: ____
Insured's ID: ____
Group Number: ____
Address: ____

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

**PATIENT INFORMATION**

Please complete this form.

NAME: Karen Morganstern

ADDRESS: 3751 Ridge Road
Anytown, CO 80000

HOME PHONE: 970-555-2929

WORK PHONE: ______

DATE OF BIRTH: 11-25-31 AGE: ______

SEX: Male ______ Female X

MARITAL STATUS: Married X Single ______
Separated ______ Divorced ______
Widowed ______

PERSON TO CONTACT IN EMERGENCY AND PHONE:
Frank Morganstern

EMPLOYED: Full Time ______ Part Time ______
Retired X Not Employed ______

EMPLOYER: ______

COMPANY ADDRESS: ______

PHONE: ______

STUDENT STATUS: Full Time ______
Part Time ______

INSURANCE COMPANY: Medicare

Insured's ID: 770-00-5613A

Group Number: ______

Address: 600 Grant St, Ste 600
Denver, CO 80203

Name of Insured: Karen

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

OTHER INSURANCE: Health Plan, Inc (Medigap Supplemental)

Insured's ID: 770 00 561301

Group Number: ______

Address: PO Box 1667
Anytown, CO 80000

Name of Insured: Karen

Date of Birth: ______

Employer: ______

Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.

NAME: **Brenton Niles**

ADDRESS: **2777 Lincoln Avenue**
**Youngstown, CO 80004**

HOME PHONE: **970-555-9111**

WORK PHONE: ____

DATE OF BIRTH: **04-15-2000** AGE: ____

SEX: Male **X** Female ____

MARITAL STATUS: Married ____ Single **X**
Separated ____ Divorced ____
Widowed ____

PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Theresa Niles 970-555-6849**

EMPLOYED: Full Time ____ Part Time ____
Retired ____ Not Employed ____

EMPLOYER: ____

COMPANY ADDRESS: ____

PHONE: ____

STUDENT STATUS: Full Time **X**
Part Time ____

INSURANCE COMPANY: **Net Life**

Insured's ID: **300-00-0848**

Group Number: **629**

Address: **PO Box 32**
**Youngstown, CO 80004**

Name of Insured: **Gary Niles**

Date of Birth: **1-29-1967**

Employer: **Western Bell**

Patient's Relationship to Insured: **child**

OTHER INSURANCE: **Blue Cross of CO**

Insured's ID: **768311900**

Group Number: **318**

Address: **PO Box 99**
**Youngstown, CO 80004**

Name of Insured: **Theresa Niles**

Date of Birth: **11-16-1967**

Employer: **Family Clinic**

Patient's Relationship to Insured: **child**



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**PATIENT INFORMATION**

Please complete this form.
NAME: **Kami Reynolds**
ADDRESS: **4675 Dixon Creek Apt 7**
**Youngstown, CO 80004**
HOME PHONE: **970-555-6996**
WORK PHONE: ____
DATE OF BIRTH: **10-12-99** AGE: ____
SEX: Male ____ Female **X**
MARITAL STATUS: Married ____ Single **X**
Separated ____ Divorced ____
Widowed ____
PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Nicole Reynolds 970-555-6996**
EMPLOYED: Full Time ____ Part Time ____
Retired ____ Not Employed ____

EMPLOYER: ____
COMPANY ADDRESS: ____

PHONE: ____
STUDENT STATUS: Full Time **X**
Part Time ____
INSURANCE COMPANY: **Medicaid**
Insured's ID: **521-00-3333**
Group Number: ____
Address: **PO Box 1461**
**Denver, CO 80203**

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

OTHER INSURANCE: ____
Insured's ID: ____
Group Number: ____
Address: ____

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

**PATIENT INFORMATION**

Please complete this form.
NAME: **Rocky Sanchez**
ADDRESS: **2621 Kings Ct**
**Yourtown, CO 80000**
HOME PHONE: **970-555-1643**
WORK PHONE: ____________
DATE OF BIRTH: **8-21-27** AGE: ____________
SEX: Male **X** Female ______
MARITAL STATUS: Married **X** Single ______
Separated ______ Divorced ______
Widowed ______
PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Ruby Sanchez**
EMPLOYED: Full Time ______ Part Time ______
Retired **X** Not Employed ______

EMPLOYER: ____________
COMPANY ADDRESS: ____________
____________
PHONE: ____________
STUDENT STATUS: Full Time ______
Part Time ______
INSURANCE COMPANY: **Medicare**
Insured's ID: **325-00-1926A**
Group Number: ____________
Address: **600 Grant St, Ste 600**
**Denver, CO 80203**

Name of Insured: ____________
Date of Birth: ____________
Employer: ____________
Patient's Relationship to Insured: ____________

OTHER INSURANCE: ____________
Insured's ID: ____________
Group Number: ____________
Address: ____________
____________

Name of Insured: ____________
Date of Birth: ____________
Employer: ____________
Patient's Relationship to Insured: ____________



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**PATIENT INFORMATION**

Please complete this form.

NAME: **Bonnie Schmidt**

ADDRESS: **1810 Bluegrass Drive**

**Springtown, CO 80002**

HOME PHONE: **970-555-9041**

WORK PHONE: **970-555-6001**

DATE OF BIRTH: **June 25, 1952** AGE: ____

SEX: Male ____ Female **X**

MARITAL STATUS: Married **X** Single ____

Separated ____ Divorced ____

Widowed ____

PERSON TO CONTACT IN EMERGENCY AND PHONE:

____

EMPLOYED: Full Time **X** Part Time ____

Retired ____ Not Employed ____

EMPLOYER: **Kain Graphics**

COMPANY ADDRESS: **1294 Main Street**

**Springtown, CO 80002**

PHONE: **970-555-6001**

STUDENT STATUS: Full Time ____

Part Time ____

INSURANCE COMPANY: **HSI**

Insured's ID: **560-00-1113**

Group Number: **208**

Address: **PO Box 324**

**Springtown, CO 80002**

Name of Insured: **Bonnie**

Date of Birth: ____

Employer: ____

Patient's Relationship to Insured: ____

OTHER INSURANCE: **CHAMPVA**

Insured's ID: **635-00-7213**

Group Number: ____

Address: **4500 Cherry Creek Dr South, Box 64**

**Denver, CO 80222**

Name of Insured: **Richard Schmidt**

Date of Birth: **September 15, 1952**

Employer: **USAF**

Patient's Relationship to Insured: **spouse**

**PATIENT INFORMATION**

Please complete this form.
NAME: Jan Scott
ADDRESS: HQ USAFE/SP PSC 5, Box 60713
Ellsworth, AFB SD 50006
HOME PHONE: 605-555-9330
WORK PHONE: 605-555-6330
DATE OF BIRTH: November 11, 1985 AGE: ______
SEX: Male ______ Female X
MARITAL STATUS: Married X Single ______
Separated ______ Divorced ______
Widowed ______
PERSON TO CONTACT IN EMERGENCY AND PHONE:
Jimmy Scott 605-555-3000
EMPLOYED: Full Time ______ Part Time X
Retired ______ Not Employed ______

EMPLOYER: Harrison Elementary School
COMPANY ADDRESS: ______

PHONE: ______
STUDENT STATUS: Full Time ______
Part Time ______
INSURANCE COMPANY: TRICARE
Insured's ID: 352005515
Group Number: ______
Address: PO Box 100502
Florence SC 29501-0502

Name of Insured: Jimmy Scott
Date of Birth: 9-13-1985
Employer: USAF
Patient's Relationship to Insured: spouse

OTHER INSURANCE: ______
Insured's ID: ______
Group Number: ______
Address: ______

Name of Insured: ______
Date of Birth: ______
Employer: ______
Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.
NAME: **Terry Shawl**
ADDRESS: **1840 Elroy St.**
**Fort Collins, CO 80520**
HOME PHONE: **970-555-7643**
WORK PHONE: ______
DATE OF BIRTH: **11-01-60** AGE: ______
SEX: Male ______ Female **X**
MARITAL STATUS: Married **X** Single ______
Separated ______ Divorced ______
Widowed ______
PERSON TO CONTACT IN EMERGENCY AND PHONE:
______
EMPLOYED: Full Time ______ Part Time ______
Retired ______ Not Employed ______

EMPLOYER: ______
COMPANY ADDRESS: ______
______
PHONE: ______
STUDENT STATUS: Full Time ______
Part Time ______
INSURANCE COMPANY: **Mountain States**
Insured's ID: **764-53-7629**
Group Number: **410**
Address: **1801 SW Vine St.**
**Denver, CO 80217**

Name of Insured: **Brian Shawl (signature on file)**
Date of Birth: **02-23-59**
Employer: **Advanced Communications**
Patient's Relationship to Insured: **spouse**

OTHER INSURANCE: ______
Insured's ID: ______
Group Number: ______
Address: ______
______

Name of Insured: ______
Date of Birth: ______
Employer: ______
Patient's Relationship to Insured: ______

**PATIENT INFORMATION**

Please complete this form.

NAME: **Emma Smith**
ADDRESS: **1410 Iris Drive**
**Mytown, CO 80001**
HOME PHONE: **970-555-5843**
WORK PHONE: ____
DATE OF BIRTH: **01-30-30** AGE: ____
SEX: Male ____ Female **X**
MARITAL STATUS: Married ____ Single ____
Separated ____ Divorced ____
Widowed **X**
PERSON TO CONTACT IN EMERGENCY AND PHONE:
____
EMPLOYED: Full Time ____ Part Time ____
Retired **X** Not Employed ____

EMPLOYER: ____
COMPANY ADDRESS: ____
____
PHONE: ____
STUDENT STATUS: Full Time ____
Part Time ____
INSURANCE COMPANY: **Medicare**
Insured's ID: **501-00-7319A**
Group Number: ____
Address: **600 Grant St Ste 600**
**Denver, CO 80203**

Name of Insured: **Emma**
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____

OTHER INSURANCE: ____
Insured's ID: ____
Group Number: ____
Address: ____
____

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship to Insured: ____



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**PATIENT INFORMATION**

Please complete this form.

NAME: **Sally Smith**

ADDRESS: **1801 Peterson Ct**

**Springtown, CO 80002**

HOME PHONE: **970-555-3255**

WORK PHONE: **970-555-2969**

DATE OF BIRTH: **11-26-60** AGE: ____________

SEX: Male ____________ Female **X**

MARITAL STATUS: Married **X** Single ____________

Separated ________ Divorced ____________

Widowed ________

PERSON TO CONTACT IN EMERGENCY AND PHONE:

**Greg Smith 970-555-7843**

EMPLOYED: Full Time **X** Part Time ____________

Retired ____________ Not Employed ____________

EMPLOYER: **Allied Professions**

COMPANY ADDRESS: **2010 Stover Street**

**Springtown, CO 80002**

PHONE: **970-555-3210**

STUDENT STATUS: Full Time ____________

Part Time ____________

INSURANCE COMPANY: **Blue Cross of IA**

Insured's ID: **321-00-1010**

Group Number: **BA1503**

Address: **PO Box 1677**

**Sioux City, IA 51102**

Name of Insured: **Sally Smith**

Date of Birth: ____________

Employer: ____________

Patient's Relationship to Insured: ____________

OTHER INSURANCE: **Mutual Insurance**

Insured's ID: **402-00-4679**

Group Number: **LA4832**

Address: **PO Box 98**

**Springtown, CO 80002**

Name of Insured: **Greg Smith**

Date of Birth: **9-2-61**

Employer: **Lakeside Auto**

Patient's Relationship to Insured: **Spouse**

**PATIENT INFORMATION**

Please complete this form.
NAME: **Amanda Tree**
ADDRESS: **35 Elm Street**
**Mytown, CO 80001**
HOME PHONE: **970-555-3234**
WORK PHONE: ____________
DATE OF BIRTH: **7-10-2001** AGE: ____________
SEX: Male ____________ Female **X**
MARITAL STATUS: Married ____________ Single **X**
Separated ____________ Divorced ____________
Widowed ____________
PERSON TO CONTACT IN EMERGENCY AND PHONE:
**Sandy 970-555-3234**
EMPLOYED: Full Time ____________ Part Time ____________
Retired ____________ Not Employed ____________

EMPLOYER: ____________
COMPANY ADDRESS: ____________

PHONE: ____________
STUDENT STATUS: Full Time **X**
Part Time ____________
INSURANCE COMPANY: **Mutual Life**
Insured's ID: **542-32-5310**
Group Number: **L558**
Address: **PO Box 911**
**Denver, CO 80111**

Name of Insured: **Sandy Tree**
Date of Birth: **2-13-1979**
Employer: **King's Food Club**
Patient's Relationship to Insured: **child**

OTHER INSURANCE: **HMO**
Insured's ID: **666-00-3519**
Group Number: **683**
Address: **PO Box 17**
**Mytown, CO 80001**
Name of Insured: **Cole Tree**
Date of Birth: **10-10-1977**
Employer: **Atlantic Engineer**
Patient's Relationship to Insured: **child**



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**PATIENT INFORMATION**

Please complete this form.
NAME: **Sandi Turner**
ADDRESS: **131 Mulberry**
**Anytown, CO 80000**
HOME PHONE: **970-555-1312**
WORK PHONE: ____
DATE OF BIRTH: **04-13-1987** AGE: ____
SEX: Male ____ Female **X**
MARITAL STATUS: Married **X** Single ____
Separated ____ Divorced ____
Widowed ____
PERSON TO CONTACT IN EMERGENCY AND PHONE:
____
EMPLOYED: Full Time ____ Part Time ____
Retired ____ Not Employed **X**

EMPLOYER: ____
COMPANY ADDRESS: ____
____
PHONE: ____
STUDENT STATUS: Full Time ____
Part Time ____
INSURANCE COMPANY: **Blue Cross of CO**
Insured's ID: **131-00-2791**
Group Number: **50**
Address: **700 Broadway**
**Denver, CO 80273**

Name of Insured: **Bob Turner**
Date of Birth: **07-23-1988**
Employer: **TSI Association**
Patient's Relationship
to Insured: **spouse**

OTHER INSURANCE: ____
Insured's ID: ____
Group Number: ____
Address: ____
____

Name of Insured: ____
Date of Birth: ____
Employer: ____
Patient's Relationship
to Insured: ____

# Physician Files

As a medical claims and billing specialist, you will gather *confidential information* on each physician you work for. The following physician information will be used to complete the CMS-1500 claim forms in your training. Take a few moments to read over each physician information card. For your convenience in completing the exercises and quizzes, this information is included in alphabetical order.

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Sarah Duncan, M.D. |
| Address: | 1414 Swallow Street |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1514 |
| Social Security: | 333-33-0003 |
| EIN: | |
| NPI: | 0203048901 |
| | Dr. Duncan is a participating provider for Blue Cross, Mutual Life and Medicare. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Clinton Fangman, M.D. |
| Corporation Name: | Stewart Center for Women |
| Address: | 1200 Carol Lane |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1010 |
| Corp. Address & Phone: | Same |
| Social Security: | 100-00-0020 |
| EIN: | 99-9009009 |
| NPI: | 0102033211 |
| Group NPI: | 0220332233 |
| | Dr. Fangman is a participating provider for Blue Cross and Medicare. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Matthew Grimm, M.D. |
| Corporation Name: | Springtown Clinic |
| Address: | 1824 Park Avenue |
| | Springtown, CO 80002 |
| Phone: | 970-555-1834 |
| Corp. Address & Phone | Same |
| Social Security: | 389-00-0110 |
| EIN: | 86-8000600 |
| NPI: | 0304851124 |
| Group NPI: | 0304455166 |
| | Dr. Grimm is a participating provider for Blue Cross and Medicaid. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | James Hahns, M.D. |
| Address: | 800 Medical Court |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-2222 |
| Office contact: | Janet Lynn, Office Manager |
| Social Security: | 900-00-9000 |
| EIN: | |
| NPI: | 0405674390 |
| | Dr. Hahns is a participating provider for all private insurance and Medicaid. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Dwight Harrison, M.D. |
| Corporation Name: | Medical Care Center |
| Address: | 100 South Main |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1111 |
| Corp. Address & Phone: | Same |
| Social Security: | 100-01-0002 |
| EIN: | 99-0000009 |
| NPI: | 6574900497 |
| Group NPI: | 6655440044 |
| | Dr. Harrison is a participating provider for Medicaid and Western Workers Insurance. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Fred Hobit, M.D. |
| Address: | 24 Mockingbird Lane |
| | Youngstown, CO 80004 |
| Phone: | 970-555-2024 |
| Office contact: | Alice Hobit, Office Manager |
| Social Security: | 801-00-0150 |
| EIN: | |
| Provider NPI: | 0155011830 |
| | Dr. Hobit is a participating provider for all private insurance. |



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**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Carolyn Hooper, M.D. |
| Corporation Name: | Stewart Center for Women |
| Address: | 1200 Carol Lane |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1010 |
| Corp. Address & Phone: | Same |
| Social Security: | 800-00-0020 |
| EIN: | 99-9009009 |
| NPI: | 0188123456 |
| Group NPI: | 0220332233 |
| | Dr. Hooper is a participating provider for Blue Cross. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Leslie Jones, M.D. |
| Corporation Name: | Medical Care Center |
| Address: | 100 South Main |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1111 |
| Corp. Address & Phone: | Same |
| Social Security: | 200-02-0008 |
| EIN: | 99-0000009 |
| NPI: | 0405891109 |
| Group NPI: | 6655440044 |
| CLIA number: | CM8402 |
| | Dr. Jones is a participating provider for Medicare Mutual Insurance and Blue Cross. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Scott Ludwig, M.D. |
| Corporation Name: | Stewart Center for Women |
| Address: | 1200 Carol Lane |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1010 |
| Corp. Address & Phone: | Same |
| Social Security: | 400-00-0404 |
| EIN: | 99-9009009 |
| NPI: | 0199654321 |
| Group NPI: | 0220332233 |
| | Dr. Ludwig is a participating provider for Blue Cross. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Donald Milford, M.D. |
| Corporation Name: | Front Range Family Care |
| Address: | 1800 Circle Court |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-3344 |
| Corp. Address & Phone: | Same |
| Social Security: | 300-03-0303 |
| EIN: | 66-6000600 |
| NPI: | 0810998051 |
| Group NPI: | 0881099885 |
| | Dr. Milford is a participating provider for TRICARE, CHAMPUS, CHAMPVA and Country Group. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Janice Ottaman, M.D. |
| Corporation Name: | Surgical Practice of CO |
| Address: | 482 Lake Drive |
| | Yourtown, CO 80000 |
| Phone: | 970-555-6456 |
| Corp. Address & Phone: | Same |
| Social Security: | |
| EIN: | 42-2400800 |
| NPI: | 0775811003 |
| Group NPI: | 0775588113 |
| | Dr. Ottman is a participating provider for all private insurance. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Clifford Phillips, M.D. |
| Corporation Name: | Medical Care Center |
| Address: | 100 South Main |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-1111 |
| Corp. Address & Phone: | Same |
| Social Security: | 100-09-0020 |
| EIN: | 99-0000009 |
| NPI: | 0275695402 |
| Group NPI: | 6655440044 |
| CLIA number: | CM8402 |
| | Dr. Phillips is a participating provider for Medicaid. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Ura Physician, M.D. |
| Address: | 1122 E. Elizabeth St. |
| | Fort Collins, CO 80525 |
| Phone: | 970-555-2791 |
| Office contact: | |
| Social Security: | |
| EIN: | 84-0732417 |
| NPI: | 0308945790 |
| | Dr. Physician is a participating |
| | provider for all private insurance. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | David Rhodes, M.D. |
| Corporation Name: | Springtown Clinic |
| Address: | 1824 Park Avenue |
| | Springtown, CO 80002 |
| Phone: | 970-555-1834 |
| Corp. Address & Phone: | Same |
| Social Security: | |
| EIN: | 86-8000600 |
| NPI: | 0189218600 |
| Group NPI: | 0304455166 |
| | Dr. Rhodes is a participating |
| | provider for all private insurance. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Albert Sands, M.D. |
| Address: | 1010 Medical Lane |
| | Main, CO 80001 |
| Phone: | 970-555-9272 |
| Office contact: | |
| Social Security: | 321-09-8765 |
| EIN: | |
| NPI: | 0388449901 |
| | Dr. Sands is a participating |
| | provider for all private insurance. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Douglas Smart, M.D. |
| Corporation Name: | Front Range Family Care |
| Address: | 1800 Circle Court |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-3344 |
| Corp. Address & Phone: | Same |
| Social Security: | 500-00-0505 |
| EIN: | 66-6000600 |
| NPI: | 0144878804 |
| Group NPI: | 0881099885 |
| | Dr. Smart is a participating provider for Preferred Coverage, Net Life and CIGNA. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Greg Stephen, M.D. |
| Corporation Name: | Front Range Family Care |
| Address: | 1800 Circle Court |
| | Yourtown, CO 80000 |
| Phone: | (970) 555-3344 |
| Corp. Address & Phone: | Same |
| Social Security: | 700-07-0007 |
| EIN: | 66-6000600 |
| NPI: | 0267679942 |
| Group NPI: | 0881099885 |
| | Dr. Stephen is a participating provider for Blue Cross HMO and Mutual Life. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Eric Sulliman, M.D. |
| Address: | 1000 Main Street |
| | Yourtown, CO 80000 |
| Phone: | 970-555-1717 |
| Office contact: | |
| Social Security: | 987-21-5432 |
| EIN: | |
| NPI: | 0377484809 |
| | |
| | Dr. Sulliman is a participating provider for all private insurance. |

**PHYSICIAN INFORMATION**

| | |
|---|---|
| Name: | Jim Wiseman, M.D. |
| Corporation Name: | Surgical Practice of CO |
| Address: | 482 Lake Drive |
| | Yourtown, CO 80000 |
| Phone: | 970-555-6456 |
| Corp. Address & Phone: | Same |
| Social Security: | |
| EIN: | 42-2400800 |
| NPI: | 0344898903 |
| Group NPI: | 0775588113 |
| | Dr. Wiseman is a participating provider for HSI, TRICARE, CHAMPUS and CHAMPVA. |

# SUMMARY OF INSURANCE PROGRAM GUIDELINES FOR THE CMS-1500 CLAIM FORM

| Field | Medicare | Medicaid | Medigap | TRICARE/CHAMPUS/CHAPVA | Private | Workers' Comp. |
|---|---|---|---|---|---|---|
| 1a | Patient's Medicare ID number. | Patient's Medicaid ID number | | Sponsor's ID number. | Patient's ID or policy number. | Patient's ID number. |
| 4 | Leave blank if Medicare is primary. | Leave blank if Medicaid is primary. | | | | Employer's name |
| 6 | Leave blank if Medicare is primary. | Leave blank if Medicaid is primary. | | | | Mark the "other" box. |
| 7 | Leave blank if Medicare is primary | Leave blank if Medicaid is primary. | | TRICARE/CHAMPUS: Active duty sponsor—type sponsor's full duty station address. If overseas, type the APO or FPO address. | | Address and phone number of employer. |
| 9 | Leave blank if no Medigap policy. | Leave blank if Medicaid is primary. | | | | |
| 9a | Leave blank if there is no Medgap policy. | Leave blank if Medicaid is primary. | If secondary policy is Medigap, type MEDIGAP and policy number. If patient has supplemental coverage through former employer, type EMPLOYER-SUPP and the patient's ID number. | | | |
| 9c | Leave blank if there is no Medigap policy. | Leave blank if Medicaid is primary. | Leave blank if Medigap PAYERID is entered in Field 9d. If PAYERID is not known, enter abbreviated Medigap address. | | | |
| 9d | Leave blank if there is no Medigap policy. | Leave blank if Medicaid is primary. | Type the PAYERID if available; otherwise type the Medigap plan name. | | | |
| 11 | Required field. If there is no insurance primary to Medicare, enter NONE. | Leave blank. | | TRICARE/CHAMPUS: If patient is covered by additional insurance, type the policy or group ID number | | |
| 11d | Leave blank. | Leave blank. | | | | |



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| Field | Medicare | Medicaid | Medigap | TRICARE/CHAMPUS/CHAPVA | Private | Workers' Comp. |
|---|---|---|---|---|---|---|
| 13 | Leave blank unless patient also has Medigap policy, then type SIGNATURE ON FILE. | Leave blank. | | TRICARE/CHAMPUS: Leave blank | | Leave blank. |
| 15 | Leave blank. | | | | | |
| 17 | Required for referring physician or if lab work or diagnosis tests using a machine are ordered. | Required for referring physician or if lab work or diagnosis tests using a machine are ordered. | | TRICARE/CHAMPUS: If patient is referred by a military treatment facility to a civilian treatment facility, type the name of the facility and attach a DD Form 2161. | | |
| 20 | Only clinical lab services performed in the physician's office can be filled on the claim. Outside labs must file their own claim for services performed. | | | | | |
| 23 | Enter physician's CLIA number if physician's office has performed lab work. | Enter physician's CLIA number if physician's office has performed lab work. | Enter physician's CLIA number if physician's office has performed lab work. | Enter physician's CLIA number if physician's office has performed lab work. | Leave blank. | |
| 24C | Leave blank. | | | | | |
| 24E | Only one diagnosis indicator per procedure is allowed. | | | | | |
| 24H | Leave blank. | Type Y if EPSDT covers services. | | Leave blank. | Leave blank. | Leave blank. |
| 27 | Required field. | | | | | |
| 29 | | | | TRICARE/CHAMPUS: Do not enter payments paid by the patient. Type only amounts received from other government programs or insurance plans. | | |
| 30 | Leave blank. | Leave blank. | | | | |

## TIPS FOR AVOIDING COMMON ERRORS ON THE CMS-1500 CLAIM FORM

- Use all capital letters.
- Do not use punctuation (e.g., hyphen, slashes, commas, dollar signs).
- Leave spaces where hyphens were used in telephone numbers.
- For other numbers, type the numbers without spaces. For example, the ID number 002-01-0001 should be typed on the claim form as 002010001.
- Use the encounter form that belongs with the exercise. Do not use encounter forms previously presented in the lesson.
- Include the carrier's address in the upper right-hand corner.
- Carefully determine the primary and secondary insured for each claim.
- Be sure to complete all applicable fields—review the *Summary of Insurance Program Guidelines* carefully.
- Include NPI numbers in Fields 24j, 32a and 33a when applicable.
- Proof the claim carefully.
    - Check spelling.
    - Check to see that information is transferred accurately.
    - Make sure Fields 1, 6, 8, 10, 11d, 20, and 27 are completed if necessary. They are easy to miss.