

HCFA 1500 Form for Auto Accident Claims

07/24/2024 3:10 pm 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'. The left sidebar contains a navigation menu with items like 'Demographics', 'Appointments', 'Clinical Dashboard', 'Documents', 'Tasks', 'Problem List', 'Medication List', 'Send eRx', 'Allergy List', 'Drug Interactions', 'CQMs', 'Intake Data', 'Lab Orders', 'Immunizations', 'Growth Charts', 'onpatient Access', and 'Education Resources'. The main content area has tabs for 'Important', 'Demographics', 'Insurances', 'Eligibility', 'Authorizations', 'Smoking Status', 'Flags', 'Balance', and 'onpatient Payments'. A red warning banner states 'BILLING WARNING: Missing Date of Birth for patient'. Below this are tabs for 'Primary Ins', 'Secondary Ins', 'Tertiary Ins', 'Auto Accident', 'Worker's Comp', and 'Durable Med Eqpt'. The 'Auto Accident' tab is active, showing a form with the following fields: 'Subscriber is the Patient' (checkbox checked), 'Insured person is the same person as the Patient' (checkbox checked), 'Auto accident company' (dropdown menu), 'Auto accident payer ID' (text field), 'Auto accident policy number' (text field), 'Auto accident case number' (text field), 'Auto accident payer address' (text area), 'Auto accident payer zip' (text field), 'Auto accident payer city' (text field), 'Auto accident payer state' (dropdown menu), 'Auto accident date of accident' (text field), 'Auto accident state of occurrence' (dropdown menu), and 'Auto accident notes' (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. ***

- 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 (dropdown menu):
 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-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

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

Employment: No
 Auto Accident: No
 Other Accident: No

Onset Date Type: Onset of Current Symptoms
 Onset date: (HCFA Box #14)
 Initial visit date: (HCFA Box #15)
 Last related visit date: (HCFA Box #19)

3) 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

ICD Version: ICD-10

Patient Payment: 0.00

Payment Notes:

Payment Posted Date: 02/16/2016

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

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

Employment: No
 Auto Accident: No
 Other Accident: No

Onset Date Type: Onset of Current Symptoms
 Onset date: (HCFA Box #14)
 Initial visit date: (HCFA Box #15)
 Last related visit date: (HCFA Box #19)

HCFA/1500 02/12 (dropdown menu):
 HCFA/1500 02/12 (text)
 New York: C4
 New York: C4.2
 New York: C4.3
 New York: C4 AUTH
 New York: NF3

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) Updated HCFA Form with Auto Accident information entered

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

<input type="checkbox"/> 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 (SEVERELY DISABLED) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>		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 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) 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"/>		7. INSURED'S ADDRESS (No., Street) 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: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) CA c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) M DD YY 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. SIGNED _____ DATE _____ 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 09 02 14		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 _____ DATE _____		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)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD10: 0		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER D. DIAGNOSIS ICD10 E. DIAGNOSIS ICD10 F. \$ CHARGES G. EXPT OR UNITS H. ICD10 I. DUAL J. RENDERING PROVIDER I.D. #		25. SUPPLIER INFORMATION			
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.

5) You can then mail or fax the claim to the auto carrier for consideration and reimbursement.