

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Tribal Clinic
Completed Claim

Main form body containing sections 1-33, including patient information, insurance details, and provider information.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

24J: Rendering physicians taxonomy with ZZ qualifier in 24I

24J: Rendering physicians NPI

24B: Place of service code

33: Location payment is sent

32: Physical location

33a: Tribal clinic NPI

33b: Tribal clinic taxonomy with ZZ qualifier