

Proper Part B Claim Submissions

1/28/2025

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Today's Presenters

Arlene
Dunphy, CPC

Provider Outreach and
Education Consultant



Carleen
Parker

Provider Outreach and
Education Consultant





Recording

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Objective

After completion attendees will be able to

- Familiarize yourself with claim submission requirements
- Avoid unnecessary claim denials and claim rejections
- Understand the benefits of electronic submissions



Agenda

- [Claim Form Requirements](#)
- [Time Limits for Filing Medicare Claims](#)
- [Claim Form Overview](#)
- [Resources, References and Tools](#)

Claim Form Requirements

Claim Submission Requirements

- Paper
 - Original CMS-1500 Claim Form
 - Use an ink jet or laser printer
 - Use Courier New font for computer-generated claims
 - Ensure no lines from the printer cartridge are anywhere on the claim
 - Use Pica 10 or 12-point typeface for claims typed
 - Use upper case letters for all claim data
 - Data should not be touching box edges or running outside of numbered boxes
 - Cannot contain more than six service lines per claim
 - No stickers, bold, italics, or underlining
- Electronic or paper
 - Do not use narrative or handwritten descriptions
 - Procedure, modifier or diagnosis
 - Do not use special characters
 - hyphens, periods, parentheses, dollar signs or ditto marks



ASCA Regulations

- Requires most providers to submit all claims electronically
- ASCA regulations exceptions include
 - Providers submitting less than ten claims per month
 - Physician/practitioner/supplier with less than ten full-time equivalent employees
 - Medicare tertiary (third) payer claims
 - Certain mass immunizers
- [ASCA Requirements for Paper Claim Submissions](#)

Time Limits for Filing Medicare Claims

Claim Filing Time Limits

- Limit is one calendar year from date of service
 - Claims not submitted timely are provider-liable
 - Beneficiary cannot be charged
- Exceptions
 - MLN Matters® [MM7270 Revised: Changes to the Time Limits for Filing Medicare Fee-For-Service Claims](#)
 - Administrative error
 - Retroactive Medicare entitlement, including when State Medicaid agencies involved
 - Retroactive disenrollment from Medicare Advantage Plan or PACE Provider Organization



Claim Form Overview

CMS-1500 Claim Form (02/12)

The image shows a scan of a CMS-1500 Health Insurance Claim Form (02/12). Two yellow arrows point to specific sections of the form:

- Beneficiary data:** Points to the top section of the form, including fields for patient name, address, date of birth, sex, and insurance information.
- Provider data:** Points to the section below the beneficiary data, which includes fields for provider name, address, and contact information.

A thick red horizontal line is drawn across the middle of the form, separating the beneficiary and provider information from the rest of the claim details.



NUCC Approved OMB

- Office of Management and Budget
 - OMB-0938-1197 1500
- 1500 Health Insurance Claim Form
 - Header
- QR code

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

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (TRICARE ID#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA (EX-LINE) (ID#) OTHER (ID#) 1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE: MM DD YY SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

ZIP CODE TELEPHONE (Include Area Code) 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 NO b. AUTO ACCIDENT? PLACE (Block) YES NO c. OTHER ACCIDENT? YES NO 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. RESERVED FOR NUCC USE 13. RESERVED FOR NUCC USE 14. RESERVED FOR NUCC USE 15. RESERVED FOR NUCC USE 16. RESERVED FOR NUCC USE 17. RESERVED FOR NUCC USE 18. RESERVED FOR NUCC USE 19. RESERVED FOR NUCC USE 20. RESERVED FOR NUCC USE 21. RESERVED FOR NUCC USE 22. RESERVED FOR NUCC USE 23. RESERVED FOR NUCC USE 24. RESERVED FOR NUCC USE 25. RESERVED FOR NUCC USE 26. RESERVED FOR NUCC USE 27. RESERVED FOR NUCC USE 28. RESERVED FOR NUCC USE 29. RESERVED FOR NUCC USE 30. RESERVED FOR NUCC USE 31. RESERVED FOR NUCC USE 32. RESERVED FOR NUCC USE 33. RESERVED FOR NUCC USE 34. RESERVED FOR NUCC USE 35. RESERVED FOR NUCC USE 36. RESERVED FOR NUCC USE 37. RESERVED FOR NUCC USE 38. RESERVED FOR NUCC USE 39. RESERVED FOR NUCC USE 40. RESERVED FOR NUCC USE 41. RESERVED FOR NUCC USE 42. RESERVED FOR NUCC USE 43. RESERVED FOR NUCC USE 44. RESERVED FOR NUCC USE 45. RESERVED FOR NUCC USE 46. RESERVED FOR NUCC USE 47. RESERVED FOR NUCC USE 48. RESERVED FOR NUCC USE 49. RESERVED FOR NUCC USE 50. RESERVED FOR NUCC USE

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 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 15. OTHER DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SW, PT, NP, etc. 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 NO 21. CHARGES \$

22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-I, to service the below (DRE) (ICD list) 23. REBATE/REASON CODE ORIGINAL REF. NO. 24. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICES From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) D. DIAGNOSIS POINTER E. CHARGES \$ F. DAYS OF 100% G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NN. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For prior claims, reversal) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING (IF GREEN OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and we made a good faith effort.) SIGNED DATE 32. SERVICE FACILITY LOCATION INFORMATION a. b. 33. BILLING PROVIDER INFO & PIN# ()

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/00/05/12

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Show Area Code)

6. IF PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Show Area Code)

8. OTHER INSURED'S NAME (Last Name & First Name & Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Cause of Pre-Exist) a. YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? d. OTHER ACCIDENT? e. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

13. INSURED'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 credits either to myself or to the party who accepts assignment below.)

14. DATE OF CURRENT SURGERY, INJURY, OR PREGNANCY CLAS (MM DD YY) QUAL. 15. OTHER DATE (MM DD YY) QUAL. 16. DATE (P) (M) (Y) (M) (D) (Y) (M) (D) (Y) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN) (17a) (17b) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUT-OF-LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the below ICD-9-CM) A. B. C. D. E. F. G. H. I. J. K. L. 22. ICD-9-CM CODE ORIGINAL REP. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (EMG) C. PROVIDER(S) (Physician, Nurse, Other) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 25. FEDERAL TAX ID NUMBER (SSN) 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE (\$) 29. AMOUNT PAID (\$) 30. PAID BY NUCC (AMOUNT)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address of credentials & ID#s that the claim is to be covered apply to this 31 and not to this part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# ()

Line Item 1

- When submitting your claims to Medicare, the Medicare box shall be checked; otherwise, your claim(s) will be rejected and returned

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary)
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)

Line Item 1a

- Enter the patient's Medicare MBI as it appears on patient's red, white and blue Medicare card for all Medicare claim submissions (primary or secondary)
 - Term "Medicare number" and "Medicare ID"
 - MBI is 11 characters in length and made up only of numbers and uppercase letters (no special characters)
 - Lowercase letters will be converted to uppercase letters
 - MBIs are assigned by SSA

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAD TRICARE CHAMPVA SEVERE DISABILITY BENEFIT
 MEDICARE MEDICAD TRICARE CHAMPVA SEVERE DISABILITY BENEFIT

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

4. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 5. OTHER INSURED'S POLICY OR GROUP NUMBER

6. PATIENT'S RELATIONSHIP TO INSURED (Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) 9. IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT? 10. IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT?

11. INSURED'S POLICY GROUP OR POLICY NUMBER 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

13. 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 other than Social Security to the party who accepts assignment below.) 14. DATE (MM DD YY) 15. SIGNATURE (Print Name, Complete with S, M, and DO)

16. DATE (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? (YES NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events that have been diagnosed) A. B. C. D. E. F. G. H. I. J. K. L.

22. ICD-9-CM CODE ORIGINAL REF NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (From To) B. PLACE OF SERVICE (Designate) C. PROCEDURE, SUPPLY OR SERVICE (Designate) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. UNIT G. RATE H. TOTAL I. D. QUAL J. REFERRING PROVIDER ID #

25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCIDENT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE (\$) 29. AMOUNT PAID (\$) 30. REBIL MISC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if apply to the title and on trade a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

1. MEDICARE MEDICAID TRICARE CHAMPVA LEGAL HEALTH PLAN SICK LEAVE OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS INC. STATE

4. CITY STATE

5. RECEIVED FOR NUCC USE

6. CITY STATE

7. ZIP CODE TELEPHONE (include area code)

8. ZIP CODE TELEPHONE (include area code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PHYSICIAN'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CLASSETT SURVIVAL, INQUIRY, OR PRESUMPTIVE CLAIM

15. OTHER DATE

16. DATE (P) DATE (M) DATE (Y) LABELS (WORK IN CURRENT OCCUPATION)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY

22. HEBEL-BERSON CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Origin, Unk, or Other) D. DIAGNOSIS FOR/PROC. E. CHARGES F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

25. FEDERAL TAX ID NUMBER SSN GN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. REMITS NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

Line Item 2

- Patient's last name, first name and middle initial list exactly as it appears on the patient's red, white and blue Medicare card

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
2	Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card
			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr., Sr.)	

Line Item 3

- Patient's eight-digit date of birth (MMDDCCYY) and check the appropriate box for patient's sex

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
3	Patient's Birth Date and gender	2010BA	DMG02 DMG03	Birth Date Gender	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8

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

PCIA PIA

1. MEDICARE MEDICAID TRICARE CHIP/STAP GROUP HEALTH PLAN SELF OR SPOUSE OTHER 1a. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last name, First name, Middle initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F) 4. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

5. OTHER INSURED'S NAME (Last name, First name, Middle initial) 6. OTHER INSURED'S POLICY OR GROUP NUMBER 7. EMPLOYMENT (Check or Precede) 8. AUTO ACCIDENT? 9. OTHER ACCIDENT? 10. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR POLICY NUMBER 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorize the release of any medical or other information necessary to process this claim. I also request payment of government contribution to my policy to the party who accepts assignment claim.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

14. DATE OF CLAIMED SURVIVAL, INJURY, OR PREGNANCY (MM DD YY) 15. OTHER DATE (MM DD YY) 16. DATE OF LAST VISIT (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAMP 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Name, AC, External, ICD-9-CM, ICD-10) 22. PRESCRIPTION CODE 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SUPPLY OR SUPPLIER D. DIAGNOSIS E. CHARGES F. PAYMENT G. INVOICE H. CLAIM I. PROVIDER J. PROVIDER ID #

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. REVENUE MISC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials to verify that the statements on this claim apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PRF ()

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SCHIP/STP/OTHER (For Programs in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS THIS CLAIM RELATED TO PREVIOUS CONDITION?

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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 or government credits other to myself or to the party who accepts assigned claim.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the designated physician or supplier for services described herein.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED

15. OTHER DATE

16. DATE OF AND NUMBER OF WORK-RELATED OCCUPATION INJURY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LABOR CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO PLACE OF SERVICE B. PROCEDURE, SERVICE, OR SUPPLIER C. DIAGNOSIS D. CHARGES E. CHARGES F. RATE G. RATE H. RATE I. RATE J. RATE K. RATE L. RATE M. RATE N. RATE O. RATE P. RATE Q. RATE R. RATE S. RATE T. RATE U. RATE V. RATE W. RATE X. RATE Y. RATE Z. RATE AA. RATE AB. RATE AC. RATE AD. RATE AE. RATE AF. RATE AG. RATE AH. RATE AI. RATE AJ. RATE AK. RATE AL. RATE AM. RATE AN. RATE AO. RATE AP. RATE AQ. RATE AR. RATE AS. RATE AT. RATE AU. RATE AV. RATE AW. RATE AX. RATE AY. RATE AZ. RATE BA. RATE BB. RATE BC. RATE BD. RATE BE. RATE BF. RATE BG. RATE BH. RATE BI. RATE BJ. RATE BK. RATE BL. RATE BM. RATE BN. RATE BO. RATE BP. RATE BQ. RATE BR. RATE BS. RATE BT. RATE BU. RATE BV. RATE BW. RATE BX. RATE BY. RATE BZ. RATE CA. RATE CB. RATE CC. RATE CD. RATE CE. RATE CF. RATE CG. RATE CH. RATE CI. RATE CJ. RATE CK. RATE CL. RATE CM. RATE CN. RATE CO. RATE CP. RATE CQ. RATE CR. RATE CS. RATE CT. RATE CU. RATE CV. RATE CW. RATE CX. RATE CY. RATE CZ. RATE DA. RATE DB. RATE DC. RATE DD. RATE DE. RATE DF. RATE DG. RATE DH. RATE DI. RATE DJ. RATE DK. RATE DL. RATE DM. RATE DN. RATE DO. RATE DP. RATE DQ. RATE DR. RATE DS. RATE DT. RATE DU. RATE DV. RATE DW. RATE DX. RATE DY. RATE DZ. RATE EA. RATE EB. RATE EC. RATE ED. RATE EE. RATE EF. RATE EG. RATE EH. RATE EI. RATE EJ. RATE EK. RATE EL. RATE EM. RATE EN. RATE EO. RATE EP. RATE EQ. RATE ER. RATE ES. RATE ET. RATE EU. RATE EV. RATE EW. RATE EX. RATE EY. RATE EZ. RATE FA. RATE FB. RATE FC. RATE FD. RATE FE. RATE FF. RATE FG. RATE FH. RATE FI. RATE FJ. RATE FK. RATE FL. RATE FM. RATE FN. RATE FO. RATE FP. RATE FQ. RATE FR. RATE FS. RATE FT. RATE FU. RATE FV. RATE FW. RATE FX. RATE FY. RATE FZ. RATE GA. RATE GB. RATE GC. RATE GD. RATE GE. RATE GF. RATE GG. RATE GH. RATE GI. RATE GJ. RATE GK. RATE GL. RATE GM. RATE GN. RATE GO. RATE GP. RATE GQ. RATE GR. RATE GS. RATE GT. RATE GU. RATE GV. RATE GW. RATE GX. RATE GY. RATE GZ. RATE HA. RATE HB. RATE HC. RATE HD. RATE HE. RATE HF. RATE HG. RATE HH. RATE HI. RATE HJ. RATE HK. RATE HL. RATE HM. RATE HN. RATE HO. RATE HP. RATE HQ. RATE HR. RATE HS. RATE HT. RATE HU. RATE HV. RATE HW. RATE HX. RATE HY. RATE HZ. RATE IA. RATE IB. RATE IC. RATE ID. RATE IE. RATE IF. RATE IG. RATE IH. RATE II. RATE IJ. RATE IK. RATE IL. RATE IM. RATE IN. RATE IO. RATE IP. RATE IQ. RATE IR. RATE IS. RATE IT. RATE IU. RATE IV. RATE IW. RATE IX. RATE IY. RATE IZ. RATE JA. RATE JB. RATE JC. RATE JD. RATE JE. RATE JF. RATE JG. RATE JH. RATE JI. RATE JJ. RATE JK. RATE JL. RATE JM. RATE JN. RATE JO. RATE JP. RATE JQ. RATE JR. RATE JS. RATE JT. RATE JU. RATE JV. RATE JW. RATE JX. RATE JY. RATE JZ. RATE KA. RATE KB. RATE KC. RATE KD. RATE KE. RATE KF. RATE KG. RATE KH. RATE KI. RATE KJ. RATE KK. RATE KL. RATE KM. RATE KN. RATE KO. RATE KP. RATE KQ. RATE KR. RATE KS. RATE KT. RATE KU. RATE KV. RATE KW. RATE KX. RATE KY. RATE KZ. RATE LA. RATE LB. RATE LC. RATE LD. RATE LE. RATE LF. RATE LG. RATE LH. RATE LI. RATE LJ. RATE LK. RATE LL. RATE LM. RATE LN. RATE LO. RATE LP. RATE LQ. RATE LR. RATE LS. RATE LT. RATE LU. RATE LV. RATE LW. RATE LX. RATE LY. RATE LZ. RATE MA. RATE MB. RATE MC. RATE MD. RATE ME. RATE MF. RATE MG. RATE MH. RATE MI. RATE MJ. RATE MK. RATE ML. RATE MM. RATE MN. RATE MO. RATE MP. RATE MQ. RATE MR. RATE MS. RATE MT. RATE MU. RATE MV. RATE MW. RATE MX. RATE MY. RATE MZ. RATE NA. RATE NB. RATE NC. RATE ND. RATE NE. RATE NF. RATE NG. RATE NH. RATE NI. RATE NJ. RATE NK. RATE NL. RATE NM. RATE NN. RATE NO. RATE NP. RATE NQ. RATE NR. RATE NS. RATE NT. RATE NU. RATE NV. RATE NW. RATE NX. RATE NY. RATE NZ. RATE OA. RATE OB. RATE OC. RATE OD. RATE OE. RATE OF. RATE OG. RATE OH. RATE OI. RATE OJ. RATE OK. RATE OL. RATE OM. RATE ON. RATE OO. RATE OP. RATE OQ. RATE OR. RATE OS. RATE OT. RATE OU. RATE OV. RATE OW. RATE OX. RATE OY. RATE OZ. RATE PA. RATE PB. RATE PC. RATE PD. RATE PE. RATE PF. RATE PG. RATE PH. RATE PI. RATE PJ. RATE PK. RATE PL. RATE PM. RATE PN. RATE PO. RATE PP. RATE PQ. RATE PR. RATE PS. RATE PT. RATE PU. RATE PV. RATE PW. RATE PX. RATE PY. RATE PZ. RATE QA. RATE QB. RATE QC. RATE QD. RATE QE. RATE QF. RATE QG. RATE QH. RATE QI. RATE QJ. RATE QK. RATE QL. RATE QM. RATE QN. RATE QO. RATE QP. RATE QQ. RATE QR. RATE QS. RATE QT. RATE QU. RATE QV. RATE QW. RATE QX. RATE QY. RATE QZ. RATE RA. RATE RB. RATE RC. RATE RD. RATE RE. RATE RF. RATE RG. RATE RH. RATE RI. RATE RJ. RATE RK. RATE RL. RATE RM. RATE RN. RATE RO. RATE RP. RATE RQ. RATE RR. RATE RS. RATE RT. RATE RU. RATE RV. RATE RW. RATE RX. RATE RY. RATE RZ. RATE SA. RATE SB. RATE SC. RATE SD. RATE SE. RATE SF. RATE SG. RATE SH. RATE SI. RATE SJ. RATE SK. RATE SL. RATE SM. RATE SN. RATE SO. RATE SP. RATE SQ. RATE SR. RATE SS. RATE ST. RATE SU. RATE SV. RATE SW. RATE SX. RATE SY. RATE SZ. RATE TA. RATE TB. RATE TC. RATE TD. RATE TE. RATE TF. RATE TG. RATE TH. RATE TI. RATE TJ. RATE TK. RATE TL. RATE TM. RATE TN. RATE TO. RATE TP. RATE TQ. RATE TR. RATE TS. RATE TT. RATE TU. RATE TV. RATE TW. RATE TX. RATE TY. RATE TZ. RATE UA. RATE UB. RATE UC. RATE UD. RATE UE. RATE UF. RATE UG. RATE UH. RATE UI. RATE UJ. RATE UK. RATE UL. RATE UM. RATE UN. RATE UO. RATE UP. RATE UQ. RATE UR. RATE US. RATE UT. RATE UV. RATE UW. RATE UX. RATE UY. RATE UZ. RATE VA. RATE VB. RATE VC. RATE VD. RATE VE. RATE VF. RATE VG. RATE VH. RATE VI. RATE VJ. RATE VK. RATE VL. RATE VM. RATE VN. RATE VO. RATE VP. RATE VQ. RATE VR. RATE VS. RATE VT. RATE VU. RATE VV. RATE VW. RATE VX. RATE VY. RATE VZ. RATE WA. RATE WB. RATE WC. RATE WD. RATE WE. RATE WF. RATE WG. RATE WH. RATE WI. RATE WJ. RATE WK. RATE WL. RATE WM. RATE WN. RATE WO. RATE WP. RATE WQ. RATE WR. RATE WS. RATE WT. RATE WU. RATE WV. RATE WW. RATE WX. RATE WY. RATE WZ. RATE XA. RATE XB. RATE XC. RATE XD. RATE XE. RATE XF. RATE XG. RATE XH. RATE XI. RATE XJ. RATE XK. RATE XL. RATE XM. RATE XN. RATE XO. RATE XP. RATE XQ. RATE XR. RATE XS. RATE XT. RATE XU. RATE XV. RATE XW. RATE XX. RATE XY. RATE XZ. RATE YA. RATE YB. RATE YC. RATE YD. RATE YE. RATE YF. RATE YG. RATE YH. RATE YI. RATE YJ. RATE YK. RATE YL. RATE YM. RATE YN. RATE YO. RATE YP. RATE YQ. RATE YR. RATE YS. RATE YT. RATE YU. RATE YV. RATE YW. RATE YX. RATE YY. RATE YZ. RATE ZA. RATE ZB. RATE ZC. RATE ZD. RATE ZE. RATE ZF. RATE ZG. RATE ZH. RATE ZI. RATE ZJ. RATE ZK. RATE ZL. RATE ZM. RATE ZN. RATE ZO. RATE ZP. RATE ZQ. RATE ZR. RATE ZS. RATE ZT. RATE ZU. RATE ZV. RATE ZW. RATE ZX. RATE ZY. RATE ZZ.

Line Item 4

- Name of the insured, if there is insurance primary to Medicare, either through the patient or spouse's employment or any other source
- Enter the word, "same," when insured is same as patient
- When Medicare is secondary payer (MSP), items 4, 6, 7 and 11 are required items

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
4*	Insured's name (When there is insurance primary to Medicare, items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	

Line Item 5

- Patient's street address on first line, city, state on second line and ZIP code and phone number on third line
- For home visits rendered in state other than patients home address, enter in Item 5 the patient's mailing address and line item 32, enter complete address, including ZIP code, where the service was actually rendered

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
5	Patient's address and telephone number	2010BA	N301	Subscriber address line 1	Enter the patient's mailing address
			N302	Subscriber address line 2	
			N401	Subscriber city name	
			N402	Subscriber state	
			N403	Subscriber ZIP code	

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/000 0012

1. MEDICARE MEDICAID TRICARE CHAMPVA GEOPOLITICAL PLAN SGLV (SGL) OTHER
 Medicare Medicaid Tricare Champva Geopolitical Plan SGLV (SGL) Other

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)
 4. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)
 6. PATIENT'S ADDRESS (No., Street)
 7. PATIENT'S ADDRESS (No., Street)
 8. CITY STATE ZIP CODE TELEPHONE (Include Area Code)
 9. CITY STATE ZIP CODE TELEPHONE (Include Area Code)

10. PATIENT'S CONDITION RELATED TO
 11. INSURED'S POLICY OR GROUP OR PLAN NUMBER
 12. PATIENTS 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 credits other than gift to the party who accepts assigned claim.)
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

14. DATE OF CURRENT SERVICE INJURY OR PREGNANCY CLASS
 15. OTHER DATE
 16. DATE OF SERVICE (NUMBER TO WORK IN CURRENT OCCUPATION)
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
 18. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)
 19. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)
 20. OUTSIDE LAB
 21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Nails AL, External or Both) (ICD-9)
 22. ICD-9 CODE ORIGINAL REF NO.
 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM TO PLACE OF SERVICE (ICD-9) B. PROCEDURE, SUPPLY OR SERVICE (ICD-9) C. DIAGNOSIS POSITION D. CHARGE E. UNIT OF MEASUREMENT F. QUANTITY G. RECEIVED PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (YES/NO) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REMAINING BALANCE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PRF ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0512

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER POLY (LINE) OTHER POLY (LINE) OTHER POLY (LINE) % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. Street) ADDRESS (No. Street)

4. CITY STATE ZIP CODE TELEPHONE (Include Area Code) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PRESENT CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR POLY NUMBER

6. OTHER INSURED'S POLICY OR GROUP NUMBER 12. EMPLOYMENT (Current or Previous) 13. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

7. RESERVED FOR NUCC USE 14. AUTO ACCIDENT? PLACE (State) 15. OTHER CLAIM? (Designated by NUCC)

8. RESERVED FOR NUCC USE 16. OTHER ACCIDENT? 17. INSURANCE PLAN NAME OR PROGRAM NAME

9. INSURANCE PLAN NAME OR PROGRAM NAME 18. CLAIM CODES (Designated by NUCC) 19. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) (If yes, complete Item 9, 10, and 11)

13. 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 or government credits other to myself or to the party who accepts assigned claim.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE 16. DATE OF BIRTH AND NUMBER TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAMP (CHAMPVA)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 60 days) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Designate Unusual Circumstances) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. ICD-9-CM G. ICD-9-CM H. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVED FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials. If both the claimant or the insurer apply to the SE and on it with a post office.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Item 6

- Complete this line item only when Items 4, 7 and 11 are completed

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
6*	Patients relationship to insured if (Complete this item only when Items 4, 7, and 11 are completed)	2320	SBR02	Required when MSP is involved 01 Spouse 18 Self 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship	

Line Item 7

- Insured's address and telephone number when Medicare is secondary payer
- Line 7 completed when Items 4, 6 and 11 are completed
- Leave blank when Medicare is primary

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
7*	Insured's address and telephone number (Complete this MSP claims)	2330A	N301	Other subscriber address line 1	Enter the mailing address of the insured. Required if other payers are known to potentially be involved in paying this claim and the information is available. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			N302	Other subscriber address line 2	
			N401	Other subscriber city name	
			N402	Other subscriber state code	
			N403	Other subscriber ZIP code	

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN IS OR WAS (LIFE) OTHER 16. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM / DD / YY) SEX (M / F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE 6. PATIENT RELATIONSHIP TO INSURED (Mar / Spouse / Child / Other) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO 10. IS EMPLOYMENT (Current or Previous) YES / NO 11. INSURED'S DATE OF BIRTH (MM / DD / YY) SEX (M / F)

12. PATIENTS 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 other than just D to the party who accepts assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM / DD / YY) QUAL () 15. OTHER DATE (MM / DD / YY) 16. DATE OF LAST WORK (MM / DD / YY) WORK IN CURRENT OCCUPATION ()

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE () 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM / TO) (MM / DD / YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABOR CHARGES ()

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the index code) (A / B / C / D / E / F / G / H / I / J / K / L) 22. PREVIOUS COORDINATION OF BENEFITS () ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE (From / To) B. PLACE OF SERVICE () C. PROCEDURE, SERVICE, OR SUPPLY () D. DIAGNOSIS () E. CHARGES () F. ICD-9-CM () G. ICD-10 () H. PROVIDING PHYSICIAN ID #

25. FEDERAL TAX ID NUMBER () 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? () 28. TOTAL CHARGE () 29. AMOUNT PAID () 30. NUMBER NUCC USE ()

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that this information is consistent with applicable law and use with a part B carrier)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & Payer ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR INDIVIDUAL OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. INSURED'S POLICY GROUP OR POLICY NUMBER

11. EMPLOYMENT (Current or Former)

12. AUTO ACCIDENT? YES NO

13. OTHER CLAIMED (Designated by NUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. CLAIM CODES (Designated by NUCC)

16. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

19. DATE

20. DATE

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE

22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

24. OUTSIDE LAB? YES NO

25. PHYSICIAN OR SUPPLIER INFORMATION

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

27. PHYSICIAN OR SUPPLIER INFORMATION

28. PRIOR AUTHORIZATION NUMBER

29. A. DATE(S) OF SERVICE

30. PROCEDURE, SERVICE, OR SUPPLIER

31. PHYSICIAN OR SUPPLIER INFORMATION

32. FEDERAL TAX ID NUMBER

33. PATIENT'S ACCOUNT NO.

34. ACCOUNT ASSIGNMENT?

35. TOTAL CHARGE

36. AMOUNT PAID

37. SIGNATURE OF PHYSICIAN OR SUPPLIER

38. SERVICE FACILITY LOCATION INFORMATION

39. BILLING PROVIDER INFO & PAY ()

Line Item 8

- Reserved for future NUCC use
- Not mapped electronically

Line Items 9, 9a-9d

- Medigap or supplemental data is appended when claims are not automatically crossed over to medigap or supplemental insurer
- If same as line Item 2, list same
- If different from line Item 2 complete, name of insured
- Policy and/or group number preceded by Medigap or MGAP or MG or payer ID
- [Medicare Coordination of Benefits Agreement](#)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAD TRICARE CHAMPVA GROUP HEALTH PLAN IS OR WAS COVERED OTHER
 Medicare Medicaid Medicaid Medicare Medicare Medicare Medicare Medicare Medicare

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 6. PATIENT RELATIONSHIP TO INSURED (MR MRS MS MSX CHILD OTHER)
 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 9a. OTHER INSURED'S POLICY OR GROUP NUMBER
 9b. RESERVED FOR NUCC USE
 9c. RESERVED FOR NUCC USE
 9d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT (Current or Previous) YES NO
 b. AUTO ACCIDENT? PLACE (State) YES NO
 c. OTHER ACCIDENT? YES NO
 11. INSURED'S POLICY OR GROUP OR FEDCA NUMBER
 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)
 13. OTHER CLAIM ID (Designated by NUCC)
 14. INSURANCE PLAN NAME OR PROGRAM NAME
 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete below, 16, 17, and 18)
 16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of Medicare benefits to the undersigned physician or supplier for services described below)
 17. SIGNATURE DATE

14. DATE OF CURRENT SURGICAL INJURY, IF PREVIOUSLY LISTED (MM DD YY) QUAL ()
 15. CLAIM DATE (MM DD YY)
 16. DATE (MM DD YY) NAME () WORK OR CURRENT OCCUPATION ()
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE ()
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY)
 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 20. OUTSIDE LAYER \$ CHARGES
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events/conditions/diagnoses)
 22. PRESCRIPTION CODE ORIGINAL REF NO
 23. PRIOR AUTHORIZATION NUMBER

1	A. DATE OF SERVICE		B. PLACE OF SERVICE	C. PROCEDURE, SUPPLIER, OR SUPPLIER IDENTIFICATION	D. DIAGNOSIS	E. CHARGES	F. PRESCRIPTION CODE	G. ORIGINAL REF NO	H. PRIOR AUTHORIZATION NUMBER	I. PROVIDING PROVIDER ID #
	From (MM DD YY)	To (MM DD YY)								
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX ID NUMBER ()
 26. PATIENT'S ACCOUNT NO
 27. ACCOUNT ASSIGNMENT? YES NO
 28. TOTAL CHARGE \$
 29. AMOUNT PAID \$
 30. FEDERAL TAX ID NUMBER ()

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if apply to the claim or to claims apply to the SE and on train a part form)
 32. SERVICE FACILITY LOCATION INFORMATION
 33. BILLING PROVIDER INFO & P# ()

EMC Equivalent Lines 9, 9a–9d

- Medigap or supplemental data is appended when claims are not automatically crossed over to medigap or supplemental insurer
- Name of insured for Medigap plan and ID
- Insured group and plan number
- Enter the city, state and ZIP code of the insurer

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
9*	Other insured's Name (Last, First, Middle Initial)	3330A	NM103	Other insured last name	Name of insured for Medigap plan
	NM104		Other insured first name		
	NM105		Other insured middle name		
9a*	Other insured's policy or group number (Medigap only)	3330A	NM106	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
			NM107	Other insured identifier	Medigap: P Primary S Secondary T Tertiary
		2020	SR031	Payer responsibility	
			SR033	Insured group or policy number	Enter the insured's group or plan number
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	3330B	N401	Other payer city name	Enter the city, state and ZIP code of the insurer. Required if any other payers are known to potentially be involved in paying this claim.
			N402	Other payer state code	
			N403	Other payer ZIP code	
9d*	Insurance plan name or program name	3330B	NM108	Other payer Identification Code Qualifier	Medigap plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 36-03-0242

1. MEDICARE MEDICAID TRICARE CHIPWA OTHER HEALTH PLAN SELA REV (LNU) OTHER 1a INSURED'S ID NUMBER (for Program in Sect 1)

2. PATIENT'S NAME, Last Name, First Name, Middle Initial 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME, Last Name, First Name, Middle Initial

5. PATIENT'S ADDRESS (incl. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (incl. Street)

8. CITY 9. RESERVED FOR FUTURE USE 10. OFFICE CITY 11. STATE

12. ZIP CODE 13. TELEPHONE (include Area Code) 14. ZIP CODE 15. TELEPHONE (include Area Code)

16. OTHER INSURED'S NAME, Last Name, First Name, Middle Initial 17. OTHER INSURED'S POLICY OR GROUP NUMBER 18. RESERVED FOR FUTURE USE 19. RESERVED FOR FUTURE USE 20. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO PLACE (State)
 c. OTHER ACCIDENT? YES NO

11. READ BACK OF FORM BEFORE PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. DATE

14. DATE OF CLAIM (include Month, Day, Year) 15. OTHER DATE 16. DATE OF SERVICE (include Month, Day, Year) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL ICD-9-CM codes below) 22. PHYSICIAN CODE 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY D. DIAGNOSIS PORTAL E. CHARGE F. DATE OF SERVICE G. ICD-9-CM H. REFERRING PROVIDER ID #

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. PAYEE ACCOUNT NO.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

Line Items 10a, 10b and 10c

- Employment, auto liability, or other accident involvement
- If checked "YES," identify primary insurance and submit to the primary and enter the two-letter state postal code for auto liability

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
10a, b, c	Is patient's condition related to employment?	2300	CLM11-1	Employment related indicator (EM)	Enter the name of the Insured's other insurance
	Auto Accident?		CLM11-1	Auto accident indicator (AA)	
	Place (State)		CLM11-4	Auto accident state	Required if Related cause code (CLM11-1,-2) = Auto Accident (AA) to identify the state in which the automobile accident occurred.
	Other Accident		CLM11-1	Other accident indicator (OA)	Required if Date of Accident (DTP01 = 439) is used and the service is employment related or the result of an accident.

Line Item 10d

- Medicaid crossovers are automatic via eligibility file-based crossover process
- Medicaid number preceded by MCD, when eligibility files are not updated with State Medicaid crossovers
- Not mapped electronically

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN (GHP) OR OTHER HEALTH PLAN (OHP) OTHER INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Mar, Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (313 area code) CITY STATE ZIP CODE TELEPHONE (313 area code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO 10. INSURED'S POLICY GROUP OR POLICY NUMBER

11. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F) 12. OTHER CLAIMS (Designated by NUCC)

13. INSURANCE PLAN NAME OR PROGRAM NAME 14. INSURED'S POLICY GROUP OR POLICY NUMBER

15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (If patient is over 18, also require payment of government contribution to group or to the party who made assignment claim) 16. PHYSICIAN OR SUPPLIER SIGNATURE (If patient is under 18, also require payment of government contribution to group or to the party who made assignment claim)

17. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMATIC CLAIM (MM, DD, YY) 18. OTHER DATE (MM, DD, YY) 19. DATE OF CURRENT OCCUPATION (MM, DD, YY)

20. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN, TIN, NPI) 21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO)

22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 23. OFFICE LAMP (YES, NO) \$ CHARGES

24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM, ICD-10-CM, ICD-9-CM, ICD-10-CM) 25. PHYSICIAN CODE ORIGINAL REF. NO.

26. A. CARRIER OF SERVICE (From, To, Place of Service, Diagnosis, Procedure, Modifier, Charge, Rate, Unit, ID, Referring Provider ID) B. PHYSICIAN CODE C. ORIGINAL REF. NO.

27. FEDERAL TAX ID NUMBER 28. PATIENT'S ACCOUNT NO. 29. ACCOUNT ASSIGNMENT? (YES, NO) 30. TOTAL CHARGE \$ 31. AMOUNT PAID \$ 32. NUMBER NUCC USE

33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that the claimant or his/her agent is the one who made a part benefit)) 34. SERVICE FACILITY LOCATION INFORMATION 35. BILLING PROVIDER INFO # ()

10d. CLAIM CODES (Designated by NUCC)

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR NON-EMPLOYED OTHER % INSURED'S ID NUMBER (For Programs in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO PREVIOUS ONE? YES NO 10. IS PRESENT CONDITION RELATED TO PREVIOUS ONE? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

11a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

11b. OTHER CLAIM ID (Designated by NUCC)

11c. INSURANCE PLAN NAME OR PROGRAM NAME

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

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 or government credits other to myself or to the party who accepts assigned claim.

13. DATE SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED QUAL. 15. OTHER DATE QUAL. 16. DATE OF BIRTH AND NUMBER OF YEARS IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Designate Unlicensed, Out-of-State, or Medicare) D. DIAGNOSIS E. CHARGES F. PAY RATE G. PAY PERCENT H. ID. QUAL. I. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (If bills to the insurer or to a reinsurer apply to the 31 and not to this part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Items 11, 11a-11d

- If Medicare primary, enter word “NONE” proceed to line Item 12
- If Medicare is secondary (MSP)
 - Insured’s policy or group number and proceed to line items 11a through 11c
 - 11a–insured eight-digit DOB and sex code
 - 11b–leave blank
 - 11c–MSP plan name
 - 11d–Not required

EMC Equivalent Line 11, 11a-11c

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
11*	Insured policy group or FECA number	2320 or 2000B	SBR01	Payer responsibility P = Primary S = Secondary T = Tertiary *Note: If Medicare is Primary, use letter 'P' and skip to item 12.	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to potentially be involved in paying this claim.
			2320	SBRO3	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	
			NM109	Insured's identifier	
		2000B or 2320	SBR05	Insurance Type Code Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"	
			2300	CLM01	
		CLM02		Monetary amount	
		2320	AMT01	Amount qualifier code = D	
			AMT02	Monetary amount (Primary Paid Claim Level)	
		2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)	
			CAS02	Claim adjustment reason codes	
			CAS03	Adjustment amount	
			CAS04	Adjustment quantity	
		2330B or 2430	DTP01	Primary insurance adjudication date	
DTP02	Date time period qualifier				
DTP03	Date paid				

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2300 or 2400	CN102	OTAF amount	
			SVD01	Identification code	
		2430	SVD02	Primary payer paid amount (line level)	
			SVD03	Medical procedure identifier	
			SVD03-1	Service ID qualifier	
			SVD03-2	Service ID	
			SVD05	Quantity	
			NM101	Entity identifier code	
			NM102	Entity type code	
		2330B	NM103	Last name or organization	
			NM108	Identification code qualifier	
NM109	Identification code				
11a*	Insured date of birth and sex-				
11b*	Employer's name or school				
11c	Insurance plan name or program name	2320	SBR04	Other Insured Group Name	Enter the complete insurance plan or program name
		2330B	NM103	Other payer organization name	Enter the complete insurance plan name
		2330B	NM109	Other payer primary identifier	Enter the payer ID of the other insurer

[Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P](#)

Line Item 12

- Signature and date
 - Informed consent to release medical information for conditions or diagnoses regulated by Federal Statutes
 - Statement permitting release of medical billing data related to claim

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
12	Patient's or authorized person's signature (Release of Information)	2300	CLM09	Release of information code	This item authorized release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service when assignment is accepted on the claim.
		2320	O106	Release of information code	I-Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not require a signature to be collected. Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN IS OR NOT COVERED OTHER
 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN IS OR NOT COVERED OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F)
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 6. PATIENT RELATIONSHIP TO INSURED (NEE, SPOUSE, CHILD, OTHER)
 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 9. OTHER INSURED'S POLICY OR GROUP NUMBER
 10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Former) YES NO
 11. INSURED'S POLICY GROUP OR FEDCA NUMBER
 12. PATIENTS 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
 13. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Former) YES NO
 14. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F)
 15. OTHER CLAIM ID (Designated by NUCC)
 16. INSURANCE PLAN NAME OR PROGRAM NAME
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Name, Address, City, State, ZIP Code, Telephone)
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO)
 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 20. OUTSIDE CLAIM? YES NO
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events relative to this claim)
 22. REFERRAL NUMBER ORIGINAL REF NO
 23. PRIOR AUTHORIZATION NUMBER
 24. A. DATES OF SERVICE (From, To) B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Special, Unlicensed, Out-of-network, Referral) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. ICD-9-CM G. ICD-9-CM H. ICD-9-CM I. ICD-9-CM J. ICD-9-CM K. ICD-9-CM L. ICD-9-CM
 25. FEDERAL TAX ID NUMBER SSN EIN
 26. PATIENT'S ACCOUNT NO
 27. ACCOUNT ASSIGNMENT? YES NO
 28. TOTAL CHARGE \$
 29. AMOUNT PAID \$
 30. FEDERAL TAX ID NUMBER
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials (I certify that the signature and the credentials apply to the SE and are valid as per below))
 32. SERVICE FACILITY LOCATION INFORMATION
 33. BILLING PROVIDER INFO & PIN# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

PCIA

1. MEDICARE MEDIGAP TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR NON-COVERED OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED

15. OTHER DATE

16. OTHER CODE

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION

20. OUTSIDE CLAIM

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. PROVIDER(S), SUPPLIER(S) OR SUPPLIER(S) D. DIAGNOSIS E. CHARGE F. ICD-9-CM G. ICD-9-CM H. NONCOVERED PROVIDER ID #

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

Line Item 13

- Signature and date
- This item authorizes payment of medigap medical benefits to physician

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
13	Insured's or Authorized Person's Signature	2300	CLM09	Benefits Assignments Certification Indicator	This item authorizes payment of medical benefits to the physician.
		2320	QI03	Assignment of Benefits Indicator	N No; W Not applicable. Use code "W" when the patient refuses to assign benefits; Y Yes

Line Item 14

- Six-digit or eight-digit date of current illness, injury, or pregnancy (LMP)
- Do not enter qualifier (QUAL) in item 14

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
14	Date if current illness, injury, pregnancy	2300	DTP03 (439)	Accident Date	Required if Related Cause code (CLM11-1, -2 or -3) = Auto Accident (AA) or Other (OA). Enter the date of current illness or injury.
		2300	DTP03 (431)	Onset of current illness or injury date	Required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service
		2300	DTP03 (454)	Initial treatment date	Required on all claims involving spinal manipulation.
		2400**	DTP03 (454)	Initial Treatment Date	Required when the initial Treatment Date is known to impact adjudication for claims involving spinal manipulation, physical therapy, occupational therapy, or speech language pathology and when different from what is reported at the claim level

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHIP/VA (CHIP/VA) GROUP HEALTH PLAN (Group Health Plan) SELF OR OTHER (Self or Other) OTHER (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No., Street, CITY, STATE, ZIP CODE, TELEPHONE (Include Area Code))

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S RELATIONSHIP TO INSURED (Spouse, Spouse, Child, Other)

6. INSURED'S ADDRESS (No., Street, CITY, STATE, ZIP CODE, TELEPHONE (Include Area Code))

7. INSURED'S POLICY OR GROUP OR POLICY NUMBER

8. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F)

9. OTHER CLAIM ID (One granted by NUCC)

10. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes, No) (If yes, complete item 11, 12, 13)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM, DD, YY) QUAL

15. HOUR/TIME/DATE(S) RELATED TO CURRENT SERVICES (FROM, TO) (MM, DD, YY)

16. DATE OF PATIENT'S BIRTH (MM, DD, YY) (If born in current jurisdiction)

17. HOUR/TIME/DATE(S) RELATED TO CURRENT SERVICES (FROM, TO) (MM, DD, YY)

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below) (A, B, C, D, E, F, G, H, I, J, K, L)

20. PHYSICIAN OR SUPPLIER IDENTIFICATION (P, Q, R, S, T, U, V, W, X, Y, Z)

21. FEDERAL TAX ID NUMBER (SRR, SSN, EIN, P, Q, R, S, T, U, V, W, X, Y, Z)

22. PATIENT'S ACCOUNT NO. (P, Q, R, S, T, U, V, W, X, Y, Z)

23. COUNTRY ASSIGNMENT? (YES, NO)

24. TOTAL CHARGE (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)

25. AMOUNT PAID (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)

26. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials (I certify that the statements on this form apply to this bill and all bills a part thereof)) (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)

27. SERVICE FACILITY LOCATION INFORMATION (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)

28. BILLING PROVIDER INFO & P/F (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR SPOUSE OTHER		14. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR POLICY NUMBER	
9. OTHER INSURED'S POLICY OR GROUP NUMBER		12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)	
10. IS PRESENT CONDITION RELATED TO:		13. INSURED'S POLICY CLAIM OR PROGRAM NAME	
15. OTHER DATE QUAL. MM DD YY		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) (If yes, complete Item 14, 15, 16, 17, 18)	
16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. PHYSICIAN OR SUPPLIER INFORMATION	
18. ADDITIONAL CLAIM INFORMATION		17. PHYSICIAN OR SUPPLIER INFORMATION	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		18. PHYSICIAN OR SUPPLIER INFORMATION	
20. A. CARRIER OF SERVICE B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS		19. PHYSICIAN OR SUPPLIER INFORMATION	
21. FEDERAL TAX ID NUMBER		20. PHYSICIAN OR SUPPLIER INFORMATION	
22. PATIENT'S ACCOUNT NO.		21. PHYSICIAN OR SUPPLIER INFORMATION	
23. SIGNATURE OF PHYSICIAN OR SUPPLIER		22. PHYSICIAN OR SUPPLIER INFORMATION	
24. SERVICE FACILITY LOCATION INFORMATION		23. PHYSICIAN OR SUPPLIER INFORMATION	
25. BILLING PROVIDER INFO & PAY ()		24. PHYSICIAN OR SUPPLIER INFORMATION	

Line Item 15

- Not required
- Not mapped electronically

Line Item 16

- Not required
- Six-digit date (MM/DD/YY) or eight-digit date (MM/DD/CCYY) when patient is employed and unable to work in current occupation
- An entry in this field may indicate employment-related insurance coverage (e.g., MSP workers' compensation)

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
16	Dates patient unable to work in current occupation (from and to)	2300	DTP03 (360)	Initial disability period start	Enter the date(s) when patient is employed and unable to work in current occupation. An entry here may indicate employment related insurance coverage.
			DTP03 (361)	Initial disability period end	

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/000 0012

PCIA

1. MEDICARE MEDICAID TRICARE CHIP/STPA GROUP HEALTH PLAN SELF OR SPOUSE OTHER

2. PATIENT'S NAME (Last name, First name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM/DD/YY) 4. INSURED'S NAME (Last name, First name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RESERVE FOR MUCC USE OFFICE STATE

ZIP CODE TELEPHONE (include Area Code) ZIP CODE TELEPHONE (include Area Code)

9. OTHER INSURED'S NAME (Last name, First name, Middle Initial) 10. IS PHYSICIAN'S CONDITION RELATED TO 11. INSURED'S POLICY OR GROUP OR PEOA NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (authorize the release of any medical or other information necessary to process this claim. I also request payment of government credit after 90 days if I am the party who accepts assignment below) DATE

13. INSURED'S DATE OF BIRTH (MM/DD/YY) 14. IS THERE ANOTHER HEALTH BENEFIT PLAN?

15. PATIENTS 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 credit after 90 days if I am the party who accepts assignment below) DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM/DD/YY TO MM/DD/YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

19. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Name, AC, ICD-9-CM, ICD-10-CM, ICD-9-CM, ICD-10-CM)

20. OFFICIAL LAB 21. ANALYSIS ON ORDER

22. PRIOR AUTHORIZATION NUMBER

23. FEDERAL TAX ID NUMBER 24. PATIENTS ACCOUNT NO. 25. TOTAL CHARGE 26. AMOUNT PAID

27. SIGNATURE OF PHYSICIAN OR SUPPLIER 28. SERVICE FACILITY LOCATION INFORMATION 29. BILLING PROVIDER INFO & P#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

1. MEDICARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> SELF OR SPOUSE <input type="checkbox"/> OTHER		14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED MM / DD / YY	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		15. OTHER DATE MM / DD / YY	
3. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code)		16. DATE OF BIRTH AND NUMBER OF WORK-RELATED OCCUPATIONAL INJURY MM / DD / YY	
4. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI	
5. PATIENT'S RELATIONSHIP TO INSURED		18. DATE RELATED TO CURRENT SERVICES TO / FROM	
6. IS PRESENT CONDITION RELATED TO a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO		19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Follow A-C for multiple terms) A. B. C. D. E. F. G. H. I. J.	
7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code)		20. PRESCRIPTION CODE ORIGINAL REF. NO.	
8. OTHER INSURED'S POLICY OR GROUP NUMBER		21. PRIOR AUTHORIZATION NUMBER	
9. RESERVED FOR NUCC USE		22. A. CARRIER OF SERVICE FROM TO PLACE OF SERVICE B. PROCEDURE, SERVICE, OR SUPPLIER C. DIAGNOSIS D. CHARGES E. PAYOR F. ID. QUAL. G. PROVIDING PHYSICIAN #	
10. IS THIS CLAIM CODES (Designated by NUCC)		23. TOTAL CHARGE 24. AMOUNT PAID 25. NUMBER NUCC USE	
11. INSURED'S POLICY GROUP OR POLICY NUMBER		26. PATIENT'S ACCOUNT NO.	
12. INSURED'S DATE OF BIRTH MM / DD / YY		27. ACCOUNT ASSIGNMENT? YES NO	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (and show payment of medical benefits to the authorized physician or supplier for services described herein)		28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT DETAILS (Print name of the physician or the provider apply to the 28 and use with a post office)	
14. SIGNED		29. SERVICE FACILITY LOCATION INFORMATION	
15. SIGNED		30. BILLING PROVIDER INFO & PAY ()	

Line Items 17 and 17b

- Type of specialty legally eligible to order and refer Part B clinical laboratory and imaging services
- First and last name of referring or ordering physician as it appears in PECOS
 - Qualifier DN, DK or DQ to left of vertical line
 - Do not use Item 17a
- List NPI of referring, ordering or supervising physician or NPP in Item 17b

EMC Equivalent Lines 17 and 17b

- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
17	Name of Referring physician or other source	2310A	NM103 (DN)	Referring provider last name	Required if claim involved a referral or services were ordered. When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (2310A) loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separate claim must be billed for each ordering/referring physician.
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
		2420F**	NM103 (DN)	Referring provider last name	
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
	Name of Ordering physician	2420E	NM103 (DK)	Ordering provider last name	
			NM104	Ordering provider first name	
			NM105	Ordering provider middle name	
17a	Other ID number of Referring physician				
17b	NPI	2310A	REF02 (1C)	Referring provider primary ID	



1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SCHOLARSHIP OTHER
 Medicare Medicaid Tricare CHIP/VA Group Health Plan Scholarship Other

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other) 7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Area Code) () 9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE 11. INSURED'S POLICY GROUP OR POLY NUMBER

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 or government credits other to myself or to the party who accepts assigned claim.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM DD YY) 15. OTHER DATE (MM DD YY) 16. DATE OF BIRTH AND NUMBER OF WORK-RELATED OCCUPATION INJURY (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) (ICD-9-CM) (ICD-9-CM) (ICD-9-CM)

21. HOSPITALIZATION CODE ORIGINAL REF. NO. 22. PRIOR AUTHORIZATION NUMBER

23. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Special, Unlicensed, or Unlicensed) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. RATE OF BENEFIT G. AMOUNT PAID H. ID. QUAL. I. NONCOVERED PROVIDER ID #

24. FEDERAL TAX ID NUMBER SSN (24) 25. PATIENT'S ACCOUNT NO. 26. ACCOUNT ASSIGNMENT? (YES NO) 27. TOTAL CHARGE 28. AMOUNT PAID 29. RESERVED FOR NUCC USE

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDE ADDRESS OR CREDIT CARDS (PRINT) that the claimant or the insurer apply to the SE and are a valid part thereof.) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PAY ()

Line Item 18

- Not required
- Admission and discharge hospital care codes related to services

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
18	Hospitalization dates related to current service (From and To)	2300	DTP03 (435)	Related hospitalization admission date	DTP01 Admission or Discharge qualifier 435 or 096
			DTP03 (096)	Related hospitalization discharge date	Enter the date when a medical service is furnished as a result of, or subsequent to, a related hospitalization. DTP (435) is required when 2300. CLM05-1 = 21, 51 or 61

Line Item 19

- Certain claim submissions do not always require an attachment
 - Enter certain dates, facts or information about service(s)
 - Routine foot care
 - Hematocrit/hemoglobin
 - Homebound
 - Not otherwise classified codes/drugs
 - Shared post operative care
 - Demonstration/clinical trails
 - Anti-markup/purchased tests
 - Claim notes

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TAN CARE CHIP/VA GROUP HEALTH PLAN OTHER (SEE INSTRUCTIONS) 16. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) () 6. PATIENT RELATIONSHIP TO INSURED (See Instructions) 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO 11. INSURED'S POLICY GROUP OR POLA NUMBER

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 other than Social Security to the party who accepts assigned claim.) 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 14, 15, and 16.)

14. DATE OF CURRENT SERVICE INQUIRY, IF PROGRAMMATIC (MM, DD, YY) 15. CLAIM DATE (MM, DD, YY) 16. DATE OF LAST WORK IN CURRENT OCCUPATION (MM, DD, YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE (FROM, TO) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. A. CARRIER OF SERVICE (From, To, Place of Service, Diagnosis, Procedure, Supplier, Other) B. PROVIDING PROVIDER'S ID #

21. FEDERAL TAX ID NUMBER 22. PATIENT'S ACCOUNT NO. 23. ACCOUNT ASSIGNMENT? YES NO 24. TOTAL CHARGE \$ 25. AMOUNT PAID \$ 26. NUMBER NUCC USE

27. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that the claimant or his/her agent is the one who signs a part below)) 28. SERVICE FACILITY LOCATION INFORMATION 29. BILLING PROVIDER INFO & Print ()

EMC Equivalent Line 19

- Loops
2300/2400/2310D/2320/2420D
- Segment/fields may differ
- For loops and fields, refer to guide for electronic claims crosswalk
 - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)

Line Item 20

- Diagnostic tests subject to anti-markup price limitations
 - Item 32 is the NPI of the provider the test were purchased from
 - Item 33 is the billing provider

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
20	Outside Lab charges	2400	PS101	Purchased Service Provider ID	Required if there are diagnostic tests subject to the anti-markup payment price limits. 2420B is required when a 2400 PS1 is present. When submitting a PS1, you must also submit the facility info in 2310C or 2420C.
		2400	PS102	Purchased Service charge amount	
		2420B	NM1	Purchase service provider	

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/000 0012

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SICK OR LONG TERM CARE OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Provide Area Code)

8. PATIENT'S BIRTH DATE (MM DD YY)

9. PATIENT'S SEX (M F)

10. PATIENT'S RELATIONSHIP TO INSURED

11. RESIDENT FOR NUCC USE

12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

13. IS PHYSICIAN'S CONDITION RELATED TO

14. EMPLOYMENT (Current or Previous)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (Designated by NUCC)

18. 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.)

19. DATE

20. SIGNED

21. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Last)

22. OTHER DATE

23. NAME OF REFERRING PROVIDER OR OTHER SOURCE

24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes for the claim)

26. OUTSIDE LAB? YES NO

27. CHARGES

28. PHYSICIAN OR SUPPLIER INFORMATION

29. FEDERAL TAX ID NUMBER

30. PATIENT'S ACCOUNT NO.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials to certify that the statements on this form apply to this bill and are made in good faith.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & P# ()

34. TOTAL CHARGE \$

35. AMOUNT PAID \$

36. REVENUE NUCC USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

PCIA

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR OTHER OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

ZIP CODE TELEPHONE (Area Code) 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PRESENT CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR POLICY NUMBER

4. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT (Current or Former) 4. INSURED'S DATE OF BIRTH MM DD YY SEX

5. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) 6. OTHER CLAIMS (Designated by NUCC)

6. RESERVED FOR NUCC USE c. OTHER ACCIDENT? 7. INSURANCE PLAN NAME OR PROGRAM NAME

8. INSURANCE PLAN NAME OR PROGRAM NAME 10c. CLAIM CODES (Designated by NUCC) 8. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 14, 16, 18, 19)

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 or government credits either to myself or to the party who accepts assigned claim. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described below.

SIGNED DATE SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE QUAL MM DD YY 16. DATE OF BIRTH AND NUMBER WORK IN CURRENT OCCUPATION FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN 17a NP 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19. OUTSIDE CLAIM # CHANGES YES NO

20. ICD-10-CM CODE ORIGINAL REF NO. 21. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. ←

A. _____ B. _____ C. _____ D. _____
 E. _____ F. _____ G. _____ H. _____
 I. _____ J. _____ K. _____ L. _____

PHYSICIAN OR SUPPLIER INFORMATION

1. NAME 2. ADDRESS 3. CITY 4. STATE 5. ZIP CODE 6. TELEPHONE (Area Code)

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. RESUBMIT NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (Only if the claimant is or has been a provider of services to the patient and not a self-pay patient) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Item 21

- Enter up to 12 diagnoses in priority order
 - primary, secondary condition
- Code to highest level of specificity for service
- ICD-10-CM indicator should be "0" for paper submitters

EMC Equivalent Line 21

- Loops 2300
 - Segment/fields HI01-02-HI12-02
- For loops and fields, refer to guide for electronic claims crosswalk
 - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



Line Item 22

- Not required
- Not mapped electronically

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHIP/PA GROUP HEALTH PLAN SELF OR RETIRED OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. Street)
 CITY STATE ZIP CODE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S RELATIONSHIP TO INSURED

6. INSURED'S ADDRESS (No. Street)
 CITY STATE ZIP CODE

7. IS THIS PATIENT'S CONDITION RELATED TO

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS THIS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENTS 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 other than just D to the party who accepts assignment below.)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMED CARE (MM/DD/YY)

15. OTHER DATE (MM/DD/YY)

16. DATE OF LAST WORK IN CURRENT OCCUPATION (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MM/DD/YY)

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM/DD/YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From A-C, Evered/line below) (ICD-9-CM)

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. A. DATE OF SERVICE (From To) (MM/DD/YY)

24. B. PROVIDER, SUPPLIER, OR SUPPLY (Designation: Physician, Other Health Professional, Supplier)

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE

29. AMOUNT PAID

30. BILLING PROVIDER INFO & PREFIX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that the claimant or his/her agent applies to this bill and on behalf of patient))

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PREFIX

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA/DCB/DCB OTHER		14. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR POLICY NUMBER	
9. OTHER INSURED'S POLICY OR GROUP NUMBER		12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)	
10. IS PRESENT CONDITION RELATED TO:		13. INSURED'S EMPLOYMENT (Current or Former)	
11. IS THIS ANOTHER HEALTH BENEFIT PLAN?		14. INSURED'S POLICY GROUP OR POLICY NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
13. DATE OF CURRENT ILLNESS, INJURY, OR PRESENTLY CLAIM		16. OTHER DATE (MM DD YY)	
14. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
15. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)		18. OUTSIDE LAB? (YES NO) \$ CHARGE	
16. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		19. PHYSICIAN OR SUPPLIER INFORMATION	
17. A. CARRIER OF SERVICE		20. PRIOR AUTHORIZATION NUMBER	
18. FEDERAL TAX ID NUMBER		21. PATIENT'S ACCOUNT NO.	
19. SIGNATURE OF PHYSICIAN OR SUPPLIER		22. SERVICE FACILITY LOCATION INFORMATION	
20. SIGNATURE OF PHYSICIAN OR SUPPLIER		23. BILLING PROVIDER INFO & PAY ()	

Line Item 23

- Ambulance ZIP code point of pick up
- CLIA ten-digit certification number
- NPI of the home health or hospice facility
 - Billing for CPO, HCPCS G0181 (HH) or G0182 (hospice)
- Prior Authorization
 - [Unique Tracking Number](#)
- Seven-digit IDE number when investigational device is used in an FDA-approved clinical trial

EMC Equivalent Line 23

- Loops
2300/2300B/2310E/2310F
 - Segment/fields REF02 with appropriate qualifier
- For loops and fields, refer to guide for electronic claims crosswalk
 - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

PCIA

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR OTHER OTHER 14. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

ZIP CODE TELEPHONE (Area Code) 9. RESERVED FOR NUCC USE ZIP CODE TELEPHONE (Area Code)

10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 11. INSURED'S POLICY GROUP OR POLY NUMBER

12. IS PRESENT CONDITION RELATED TO 13. INSURED'S DATE OF BIRTH MM DD YY SEX

14. EMPLOYMENT (Current or Former) 15. AUTO ACCIDENT? PLACE (State) 16. OTHER CLAIM? (Designated by NUCC)

17. IS THIS ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 18, 19, 20, 21)

18. INSURED'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 or government credits other than to myself or to the party who accepts assigned claim. SIGNED DATE

19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below. SIGNED DATE

20. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 21. OTHER DATE QUAL MM DD YY 22. ORDER OF AND NUMBER TO WORK IN CURRENT OCCUPATION FROM TO

23. NAME OF REFERRING PROVIDER OR OTHER SOURCE 24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 26. OUTSIDE LAB? \$ CHARGE YES NO

27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 12 months) 28. PHYSICIAN CODE ORIGINAL REF NO

29. PRIOR AUTHORIZATION NUMBER

LINE	DATE OF SERVICE	ICD-9-CM CODE	PROCEDURE CODE	UNIT	CHARGE	RENDERING/PERFORMING PHYSICIAN OR NPP
1						
2						
3						
4						
5						
6						

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OF OFFICE (This certifies that the diagnosis or procedure apply to the bill and are in accordance with the plan terms.)

30. SERVICE FACILITY LOCATION INFORMATION

31. BILLING PROVIDER INFO & PAY ()

32. RECEIPTED NUMBER

33. PATIENT'S ACCOUNT NO

34. COINSURANCE? YES NO

35. TOPAL CHARGE

36. READY PAY

37. FINDER FEE/COM

38. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OF OFFICE (This certifies that the diagnosis or procedure apply to the bill and are in accordance with the plan terms.)

39. SERVICE FACILITY LOCATION INFORMATION

40. BILLING PROVIDER INFO & PAY ()

41. RECEIPTED NUMBER

42. PATIENT'S ACCOUNT NO

43. COINSURANCE? YES NO

44. TOPAL CHARGE

45. READY PAY

46. FINDER FEE/COM

Line Items 24A-24J

- Paper claim contains six-line items
 - 24A: Date of service
 - 24B: Place of service
 - 24C: Not used
 - 24D: CPT/HCPCS, modifier(s)
 - 24E Diagnosis code pointer
 - 24F: Charge/fee for service
 - 24G: Units
 - 24H: Not used
 - 24I: Not used
 - 24J: Rendering/performing physician or NPP

EMC Equivalent Lines 24A–24J

- Loops
 - 2010AA/2300/2310B/2400/2420A
- Segment/fields
 - DTP/CLM/SV101-107/REF/NM109/AMT
- For loops and fields, refer to guide for electronic claims crosswalk
 - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2003

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR NON-EMPLOYEE OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM DD YY) SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS THIS CLAIM RELATED TO: a. EMPLOYMENT (Current or Former) b. AUTO ACCIDENT? c. OTHER ACCIDENT? d. OTHER CLAIMED (Designated by NUCC)

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. INSURED'S DATE OF BIRTH (MM DD YY) SEX

13. INSURANCE PLAN NAME OR PROGRAM NAME

14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 14, 15, and 16)

15. INSURED'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 or government credits other to myself or to the party who accepts assigned claim.)

16. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL applicable ICD-9-CM codes)

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

21. OUTSIDE LABOR CHARGES

22. PHYSICIAN ORDER ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Designate Unlicensed Practitioner) D. PHYSICIAN ORDER E. CHARGES F. PAY BY DATE G. PAY TO H. ID. QUAL. I. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID. NUMBER SSN EIN

26. ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. REVIEW NUCC USE

31. BILLING PROVIDER INFO & PAY ()

Line Item 25

- Enter provider of service Federal Tax ID, EIN or SSN of billing provider/group

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
25	Federal Tax ID number	2010AA	REF02	Billing Provider Tax ID	Enter the provider of service Federal Tax ID/EIN (EI) or SSN (SY) of the billing provider/group.
	SSN Indicator		REF01	Social Security number	
	EIN Indicator		REF01	Employer's ID number	

Line Item 26

- Enter patient's account number assigned by provider
- An account number will be returned up to 20 characters

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
26	Patient's Account number	2300	CLM01	Provider Assigned Account number	Enter the patient's account number assigned by the provider of service's accounting system. As a service, any account number will be returned to you up to 20 characters.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR RETIRED OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. Street)

4. PATIENT'S DATE OF BIRTH (MM/DD/YY)

5. PATIENT'S RELATIONSHIP TO INSURED

6. INSURED'S NAME (Last Name, First Name, Middle Initial)

7. INSURED'S ADDRESS (No. Street)

8. INSURED'S DATE OF BIRTH (MM/DD/YY)

9. INSURED'S POLICY GROUP OR POLICY NUMBER

10. IS THIS CLAIM RELATED TO ANOTHER CLAIM?

11. IS THERE ANOTHER HEALTH BENEFIT PLAN?

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUS CLAIM

15. CLAIM DATE (MM/DD/YY)

16. DATE OF LAST WORK IN CURRENT OCCUPATION

17. NAME OF REPORTING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (MM/DD/YY)

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. BILLING PROVIDER INFO

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (01)

PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR INDIVIDUAL OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PRESENT CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. OTHER INSURED'S POLICY OR GROUP NUMBER

13. EMPLOYMENT (Current or Former)

14. INSURED'S DATE OF BIRTH SEX

15. RESERVED FOR NUCC USE

16. AUTO ACCIDENT? PLACE (State)

17. RESERVED FOR NUCC USE

18. OTHER ACCIDENT? PLACE (State)

19. INSURANCE PLAN NAME OR PROGRAM NAME

20. IS THERE ANOTHER HEALTH BENEFIT PLAN?

21. 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 or government credits other than to myself or to the party who accepts assignment below.

22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described below.

23. DATE SIGNED

24. STATE OF CURRENT RESIDENCE, COUNTY, IF PREVIOUSLY CLAIMED

25. OTHER DATE QUAL. MM DD YY

26. ORDER NO. AND NUMBER TO WORK IN CURRENT OCCUPATION FROM TO

27. NAME OF REFERRING PROVIDER OR OTHER SOURCE

28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

30. OUTSIDE LAB? CHARGER

31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events within 60 days)

32. PRESCRIPTION CODE ORIGINAL REF. NO.

33. PRIOR AUTHORIZATION NUMBER

34. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS E. CHARGER F. ORDER NO. G. ORDER NO. H. ORDER NO. I. ORDER NO. J. ORDER NO. K. ORDER NO. L. ORDER NO. M. ORDER NO. N. ORDER NO. O. ORDER NO. P. ORDER NO. Q. ORDER NO. R. ORDER NO. S. ORDER NO. T. ORDER NO. U. ORDER NO. V. ORDER NO. W. ORDER NO. X. ORDER NO. Y. ORDER NO. Z. ORDER NO.

35. FEDERAL TAX ID NUMBER

36. PATIENT'S ACCOUNT

37. TOTAL CHARGE

38. AMOUNT PAID

39. NUMBER NUCC USE

40. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (I certify that the charges to be billed comply with the UB and are in compliance with the law.)

41. SERVICE FACILITY LOCATION (If applicable)

42. BILLING PROVIDER INFO & PAY ()

27. ACCEPT ASSIGNMENT? (BY PHIL. DRUGS, USE 9999)
 YES NO

Line Item 27

- Assignment: check yes or no
- Mandatory assignment for certain services
 - Clinical diagnostic laboratory services and physician lab services
 - Physician services to individuals dually entitled to Medicare and Medicaid
- Mandatory assignment for certain practitioners and providers
 - Physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	CLM07	Assignment or Plan Participation code	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not assigned

Line Items 28, 29 and 30

- Item 28 is total charges on claim
- Item 29 leave blank
 - Often misunderstood
 - Allocates payment to beneficiary
- Item 30 is not used

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
28	Total Charges	2300	CLM02	Total claim charge amount	Enter total charges for services.
29	Amount paid	2300	AMT02	Total patient amount paid	AMT01 Amount qualifier code=F5 Required if the patient has paid any amount towards the claim for covered services only.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER
 Medicare Medicaid Tricare CHAMPVA GROUP HEALTH PLAN OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No. Street)
 6. PATIENT RELATIONSHIP TO INSURED
 7. INSURED'S ADDRESS (No. Street)
 8. CITY STATE ZIP CODE TELEPHONE (Area Code)
 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 10. IS PRESENT CONDITION RELATED TO:
 11. INSURED'S POLICY OR GROUP OR FICA NUMBER
 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 due to myself or to the party whose assignment I request indicated below.)
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY LOST WORK (MM DD YY) QUAL (1 2 3 4 5 6 7 8 9) 15. CLAIM DATE (MM DD YY) 16. DATE (MM DD YY) NAME (LAST FIRST MIDDLE) WORK OR CURRENT OCCUPATION (FROM TO)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (NAME) (SSN) (17A NP) 18. HOSPITAL/CLINICAL DATES RELATED TO CURRENT SERVICES (FROM TO)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES (YES NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events/active below) (ICD-9-CM) (ICD-10) 22. HIRER/EMPLOYER CODE ORIGINAL REP. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (C) PROCEDURES, SERVICES, OR SUPPLIES (Diagnoses, Unwitnessed, Observation, Medication) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. CPT/HCPCS G. QUAL. H. REFERRING PROVIDER'S #

25. FEDERAL TAX ID NUMBER SSN (25A) (25B) 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use

27. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials if party that the claim is for the claimant or the claimant's parent) 28. SERVICE FACILITY LOCATION INFORMATION 29. BILLING PROVIDER INFO & P#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR COV (LEAD) OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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 or government credits other than cash to be paid to the party whose name is assigned below.)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED

15. OTHER DATE

16. DATE OF BIRTH AND NUMBER TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. OUTSIDE LABOR CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS E. CHARGES F. PAY RATE G. PAY PERIOD H. ICD-9 CODE I. PROVIDING AGENCY ID #

25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. REVIEW NUGO USE

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PAY ()

Line Item 31

- Paper submitters
 - Signature of provider or representative and six-digit or eight-digit date form was signed
- Electronic submitters
 - Y=Provider signature on file
 - N=Provider signature not on file

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
30	Balance due	N301			
31	Signature of physician or supplier including degrees or credentials	2300	CLM06	Provider or supplier signature indicator	Y=Provider signature is on file N=Provider signature is not on file

Line Item 32

- Place of service required on all claims
 - Name, address and ZIP code

32	2310C	NM103 (77)	Laboratory or Service Facility Name	NM101 Entity Identifier code=77 - Service Location Required when the location of the service is different than that carried in 2010AA-Billing Provider (Item 32). Enter the name, address city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, and zip code. Required when the location of health care service is different than that carried in the Billing Provider Name (2010AB) loops.
		N301	Laboratory or Service Facility address 1	
		N302	Laboratory or Service Facility address 2	
		N401	Laboratory or Service Facility city	
		N402	Laboratory or Service Facility state	
	2420C**	NM103 (77)	Laboratory or Service Facility Name	Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address. If an independent laboratory is billing enter the place where the test were performed. Complete this information for all laboratory work performed outside a physician's office. If the service was referred to an outside lab, enter the reference labs name and address. Providers of service must identify the supplier's name, address and NPI when billing for anti-markup tests. If the acquisition provider is out of jurisdiction, you should use the billing provider's NPI. Only bill one unique facility number per claim.
		N301	Laboratory or Service Facility address 1	
		N302	Laboratory or Service Facility address 2	
		N401	Laboratory or Service Facility city	
		N402	Laboratory or Service Facility state	
N403	Laboratory or Service Facility ZIP code			

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

PCIA PIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR INDIVIDUAL OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

8. PATIENT'S DATE OF BIRTH (MM/DD/YY)

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

11. INSURED'S NAME (Last Name, First Name, Middle Initial)

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Include Area Code)

17. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

18. OTHER INSURED'S POLICY OR GROUP NUMBER

19. IS PHYSICIAN'S CONDITION RELATED TO EMPLOYMENT (Check if Primary) YES NO

20. IS AUTO ACCIDENT? YES NO

21. IS OTHER ACCIDENT? YES NO

22. IS CLAIM CODES (Designated by NUCC) YES NO

23. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 10, and 11)

24. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (Authorize the release of any medical or other information necessary to process this claim. I also request payment of government contribution to my plan if I am the party who accepts assignment claim.)

25. DATE

26. SIGNED

27. DATE OF CLAIMED ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)

28. NAME OF REFERRING PROVIDER OR OTHER SOURCE

29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Name, ALIC, ICD-9-CM, ICD-10-CM)

31. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)

32. HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS (FROM MM/DD/YY TO MM/DD/YY)

33. OUTSIDE LAB? YES NO

34. LABORATION CODE

35. PRIOR AUTHORIZATION NUMBER

36. FEDERAL TAX ID NUMBER

37. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials to verify that the statements on this invoice apply to this bill and are made a part thereof.)

38. BILLING PROVIDER INFO & PFI#

39. SERVICE FACILITY LOCATION INFORMATION

40. TOTAL CHARGE

41. AMOUNT PAID

42. REMAINING BALANCE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR SPOUSE OTHER
 Medicare Medicaid Tricare CHIP/VA Group Health Plan Self or Spouse Other

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

ZIP CODE TELEPHONE (Area Code) () ZIP CODE TELEPHONE (Area Code) ()

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PRESENT CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR FICA NUMBER

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 or government credits other to myself or to the party who accepts assigned claim.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE 16. ORDER (or NUMBER) WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABORATORY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 60 days) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. PHYSICIAN IDENTIFICATION E. CHARGE F. ICD-9-CM G. ICD-10 H. REFERRING PROVIDER ID #

25. FEDERAL TAX ID NUMBER 26. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office unless it differs from the address to be billed; apply to the bill and not to this part thereof.) 27. BILLING PROVIDER INFO & PAY ()

28. SERVICE FACILITY LOCATION INFORMATION

29. TOTAL CHARGE 30. AMOUNT PAID 31. RESERVED FOR NUCC USE

Line Items 32 and 32a

- All claims require place of service line item 32
 - Ambulance claims
 - Laboratory or service facility
 - Mammography certification
- Purchased test require both 32 and 32a

32a	NPI	7310C	NM109 (ZZ)	Laboratory/Facility Primary Identifier	Enter the NPI of the Service Facility. Enter "XX" in the NM108 to indicate the NPI is present in the NM108.
		2400C**	NM109 (ZZ)		
		2400	PS101	Purchased service provider identifier	
		2420U	NM101	Identification code qualifier =00	
			NM108	Identification code=XX	
			NM109	Identification code	
			NM101	Identification code qualifier =0R	
			NM108	Identification code	
			NM109	Identification code	
		2300	REF01	Reference Identification qualifier =6W	
REF02	Mammogram FICA number				

Line Items 33 and 33a

- Required on all claims
 - Provider's billing name, address and ZIP code
- Item 33a contains NPI of billing practice

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
33	Physician's supplier's billing name, address, zip code & phone number	2010AA or 2010AB	NM103 (85)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
			NM104	Provider first name	NM101 Entity Identifier=87-Pay-to-provider
			NM105	Provider middle initial	
			N301	provider address 1	NM102 Entity Type code 1 Person 2 Non-Person Entity Enter the provider or service/supplier's billing name, address, zip code and telephone number. Must be a physical address with nine-digit ZIP code.
			N401	Provider city	
			N402	Provider state	
			N403	Provider ZIP code	
PER04	Provider phone number				
33a	NPI	2010AA	NM109 (85)	Provider ID	NM101 Entity Identifier code=85-Billing Provider NM101 Entity Identifier code=87-Pay-to-provider Enter the NPI for the Group Number or for the performing provider of service/supplier who is a member of a group practice. Enter "XX" in the NM108 to indicate an NPI is present in the NM109

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

1. MEDICARE MEDICAID TRICARE CHAMPVA DECAT HEALTH PLAN OTHER 14. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

8. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE 11. INSURED'S POLICY GROUP OR PLAN NUMBER

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 other than part of the party who accepts assignment below.) 13. IS PATIENT'S CONDITION RELATED TO 14. EMPLOYMENT (Date of Termination) 15. INSURED'S DATE OF BIRTH SEX 16. OTHER CLAIM ID (Date paid by NUCC) 17. INSURANCE PLAN NAME OR PROGRAM NAME 18. IS THERE ANOTHER HEALTH BENEFIT PLAN? 19. INSURED'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 other than the assigned physician or supplier or services described below.)

18. DATE OF SERVICE (Month, Day, Year) 19. CLAIM DATE (Month, Day, Year) 20. DATE OF SERVICE (Month, Day, Year) 21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (From, To)

22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 23. OUTSIDE LAB? (Yes/No) 24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below) 25. PRELIMINARY CODE (ORIGINAL PIP NO) 26. PRIOR AUTHORIZATION NUMBER

27. A. DATE OF SERVICE (From, To) B. PLACE OF SERVICE (EMS, OP/PC/POS) C. PROCEDURE, SUPPLY, OR SUPPLIER (CPT/HCPCS, DRUGS, SUPPLIES) D. DIAGNOSIS POSITION (ICD-9-CM) E. CHARGES (UNIT, RATE, NO. OF UNITS, QTY) F. PROVIDING PROVIDER ID #

28. FEDERAL TAX ID NUMBER 29. PATIENT'S ACCOUNT NO. 30. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statement on this invoice applies to this bill and see it with a part thereof.) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & P.I. (NPI)

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

The information contained in this crosswalk is for reference purposes only.

* = If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.

** = Use if different than information given at the claim level. 7/6/2012 - KJT 1

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary)
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)
2	Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card
			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr. Sr.)	
3	Patient's Birth Date and gender	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8
			DMG03	Gender	
4*	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	

Claim Rejection Reminders

- Claim rejections CO16, MA130
 - Claims received that contain incomplete or invalid information will be “rejected” and returned as unprocessable
- Unprocessable claims have
 - No appeal rights
 - No reopening rights
- Resubmit a new claim with corrected information
- [Unprocessable Claim Rejections and Corrections](#)

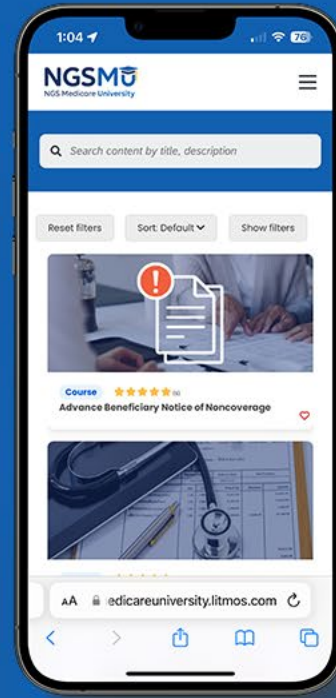
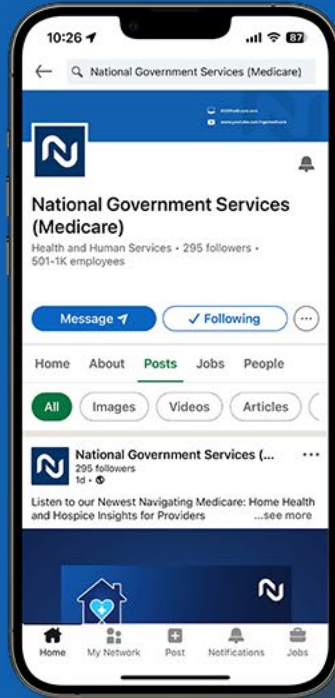
Resources, References and Tools

Resources and References

- [NGS website](#)
 - [CMS-1500 Claim Form Completion Instructions](#)
 - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)
 - [Top Claim Errors](#)
- [CMS website](#)
- [Place of Service Code Sets](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual](#)
 - [Chapter 1, General Billing Requirements](#)
 - [Chapter 26, Completing and Processing Form CMS-1500](#)

Questions?

Thank you!



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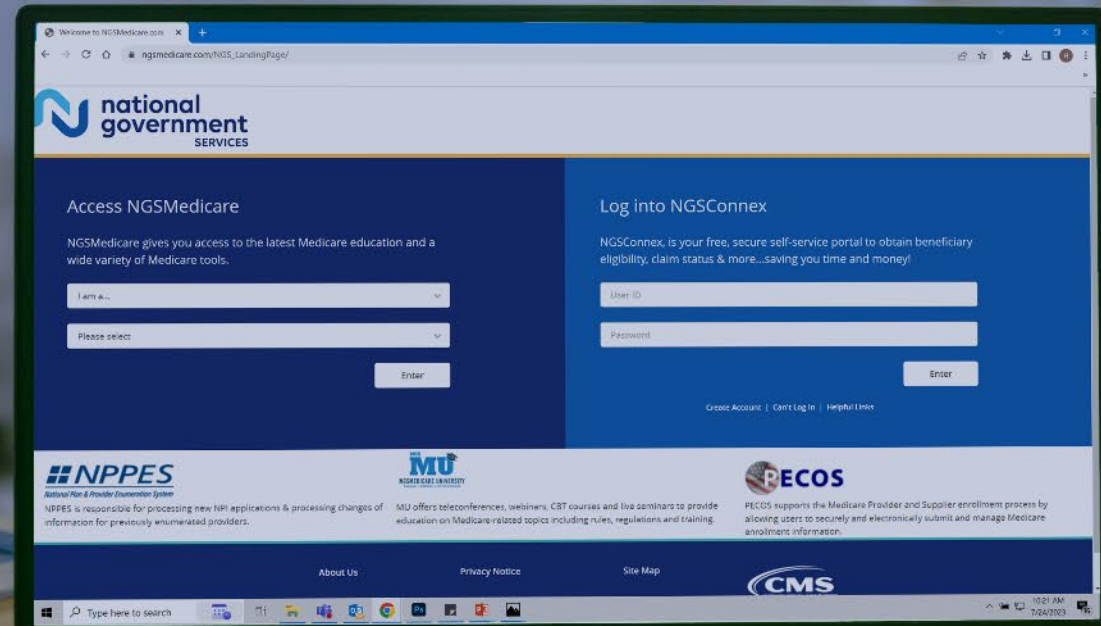


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Online resources, event calendar, LCD/NCD, and tools



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