

Proper Part B Claim Submissions

2/26/2025

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Today's Presenters

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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)

Beneficiary data

Provider data

HEALTH INSURANCE CLAIM FORM

SECTION 1: PATIENT AND INSURER INFORMATION

SECTION 2: PROVIDER INFORMATION

SECTION 3: CLAIM INFORMATION

SECTION 4: PATIENT INFORMATION

SECTION 5: SERVICE INFORMATION

SECTION 6: ADJUSTMENT INFORMATION

SECTION 7: SIGNATURES

SECTION 8: OTHER INFORMATION



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 (FECA LINE#) (ID#) OTHER (ID#)

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. RESERVED FOR NUCC USE

9. RESERVED FOR NUCC USE

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 (d. RESERVED FOR LOCAL USE)

11. INSURED'S POLICY GROUP OR FECA 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 #yes, complete items 9, 10 and 11)

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 report or to the party who accepts assignment below.

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (DPA, DTS, NPI) 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? \$ CHARGES (YES NO) 21. REBATE/REASON CODE ORIGINAL REF. NO. 23. 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 (E) DIAGNOSIS POINTER (F) \$ CHARGES (G) DAYS OF SUPPLY (H) I. RATE (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. 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-EN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For prior claims, see back) 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 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: a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT SURGERY, INJURY, OR PREGNANCY CLAS 15. OTHER DATE QUAL. MM DD YY 16. DATE PATIENT BECAME UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. ADDITIONAL CLAIM INFORMATION

19. ADDITIONAL CLAIM INFORMATION

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. DATE OF SERVICE FROM TO 22. PROVIDER'S ICD-9-CM OR SUPPLIER'S ICD-9-CM

23. MEDICAL TAX ID NUMBER 24. PATIENT'S ACCOUNT NO. 25. ACCEPT ASSIGNMENT? 26. TOTAL CHARGE 27. AMOUNT PAID 28. SERVICE FACILITY LOCATION INFORMATION 29. 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
 MEDICARE MEDICAD TRICARE CHAMPVA SEVERE DISABILITY

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

8. OTHER INSURED'S POLICY OR GROUP NUMBER 9. EMPLOYMENT (Current or Former) YES NO 10. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

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 of government benefits other than Social Security to the party who accepts assignment below.) 13. IS THIS CLAIM RELATED TO: (a) EMPLOYMENT (Current or Former) YES NO (b) ALCOHOLIC PLACE (State) YES NO (c) OTHER ACCIDENT? YES NO

14. DATE OF CURRENT SURVIVAL SURVIVAL OR PRESUMEDLY DEAD (MM DD YY) 15. CLAIM DATE (MM DD YY) 16. DATE (MM DD YY) WHEN OCCURRENCE OCCURRED (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SN 17A NR) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) 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 REP. 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. ICD-9-CM G. ICD-9-CM H. ICD-9-CM I. PROVIDING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if apply to the SN and on trade or post holder) 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 OTHER HEALTH PLAN (For Program in Item 1)

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

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

4. PATIENT'S ADDRESS (No. & Street)

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

6. RECEIVED FOR NUCC USE

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

8. OTHER INSURED'S POLICY OR GROUP NUMBER

9. RECEIVED FOR NUCC USE

10. RECEIVED FOR NUCC USE

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 of government benefits other than Social Security to the party who accepts assignment below.)

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 OF CLAIM (Month, Day, Year) QUAL. MM DD YY

15. OTHER DATE QUAL. MM DD YY

16. DATE (P) (M) (D) (Y) (M) (D) (Y) (M) (D) (Y)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Include ALL ICD-9-CM codes below)

22. HILB/REVISION 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 ICD-9-CM E. CHARGE F. 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. KK. 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. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VV. 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. 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 ID NUMBER SSN GN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. RECEIVED FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials (certify that the statements on this cover apply to this bill and can be used as part thereof))

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 PICA

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) 5. PATIENT'S CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. OTHER INSURED'S NAME (Last name, First name, Middle initial) 7. IS PHYSIAN'S CONDITION RELATED TO EMPLOYMENT? (Circle or Print) YES NO 8. EMPLOYER'S DATE OF BIRTH (MM DD YY) SEX (M F)

9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. IS PHYSIAN'S CONDITION RELATED TO AUTO ACCIDENT? (Circle or Print) YES NO 11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorizes the release of any medical or other information necessary to process this claim. Also request payment of government contribution to input ID to the party who accepts assignment claim.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorizes 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 CLAIM (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION 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 (Name, AC, External, ICD-9-CM, ICD-10) 22. PRESCRIPTION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (Inpatient, Outpatient, Home, etc.) C. PROCEDURE, SUPPLY, OR SUPPLIER (ICD-9-CM, HCPCS, etc.) D. DIAGNOSIS (ICD-9-CM, ICD-10) E. CHARGES (Per Unit, Per Day, etc.) F. AMOUNT PAID (Per Unit, Per Day, etc.) G. IDENTIFY PROVIDER (Last Name, First Name, Middle Initial, Suffix, etc.) H. PROVIDER ID #

25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE (A) 29. AMOUNT PAID (B) 30. INVOICED BY (C) 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials to certify that the statement on this invoice applies to the bill and can't be a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ()

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN 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 PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Former)?

11. INSURED'S POLICY GROUP OR POLA 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. DATE OF AND NUMBER OF WORK-RELATED OCCUPATIONAL 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

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. REVIEW NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

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 3/00/0212

1. MEDICARE MEDICAID TRICARE CHAMPVA GEOP/SETPA PLAN SGLV (SGLS) OTHER
 Medicare Medicaid Tricare CHAMPVA GEOP/SETPA PLAN SGLV (SGLS) OTHER

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

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

6. OTHER INSURER'S POLICY OR GROUP NUMBER 7. EMPLOYMENT (Current or Pending) YES NO 8. AUTO ACCIDENT? YES NO PLACE (State) 9. OTHER CLAIM? (One paid by NUCC) YES NO 10. OTHER ACCIDENT? YES NO 11. INSURER'S POLICY OR GROUP OR PLAN NUMBER 12. INSURER'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 13. OTHER CLAIM? (One paid by NUCC) YES NO 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 14, and 15)

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 paid to the party who accepts assignment below.) WITNESSED DATE SIGNED 13. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.) SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLASS (MM/DD/YY) QUAL. 15. OTHER DATE (MM/DD/YY) 16. DATE PATIENT CAME TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN IFA IFA) 18. HOUR TO START DATE 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. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Nucleic Acid, Enzyme, or Other) (ICD-9-CM) A. B. C. D. E. F. G. H. I. J. 22. ICD-9-CM CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE (RMS) C. PROCEDURE, SUPPLY, OR SERVICE (ICD-9-CM) D. DIAGNOSIS POSITION E. CHARGE F. CHARGE G. RATE OF PAY H. RATE OF PAY I. RATE OF PAY J. RATE OF PAY

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees 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 ()

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) 12. EMPLOYMENT (Current or Previous)

7. RESERVED FOR NUCC USE 13. AUTO ACCIDENT? PLACE (State) 13. AUTO ACCIDENT? PLACE (State)

8. RESERVED FOR NUCC USE 14. OTHER ACCIDENT? 14. OTHER ACCIDENT?

9. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS CLAIM CODES (Designated by NUCC) 15. IS CLAIM CODES (Designated by NUCC)

10. 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. SIGNED: DATE: SIGNED: DATE:

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

12. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17. HOSPITAL/CLINICAL DATES RELATED TO CURRENT SERVICES 17. HOSPITAL/CLINICAL DATES RELATED TO CURRENT SERVICES

13. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 18. OUTSIDE LAMP 18. OUTSIDE LAMP

14. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the below boxes) 19. PHYSICIAN CODE ORIGINAL REF. NO. 19. PHYSICIAN CODE ORIGINAL REF. NO.

20. A. DATE(S) OF SERVICE FROM TO B. C. D. PROCEDURE, SERVICE, OR SUPPLIER B. D. DIAGNOSIS 20. A. DATE(S) OF SERVICE FROM TO B. C. D. PROCEDURE, SERVICE, OR SUPPLIER B. D. DIAGNOSIS

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

27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (If bills to the insurer or to the insurer apply to the bill and are in a part thereof) 28. SERVICE FACILITY LOCATION INFORMATION 29. BILLING PROVIDER INFO & PAY ()

6. PATIENT RELATIONSHIP TO INSURED
 Self Spouse Child Other

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 IN CURRENT OCCUPATION (MM / DD / YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE () 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 events in the index code) A. () B. () C. () D. () E. () F. () G. () H. () I. () J. () 22. PRESCRIPTION CODE 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. () G. () H. () I. () J. ()

25. FEDERAL TAX ID NUMBER () 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 (Include degree or credentials (Verify that the claimant or his/her agent applies to this bill and not to a joint bill)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAYER ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR POLY (LEAF) 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)	
3. PATIENT'S BIRTH DATE MM DD YY SEX		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED		9. INSURED'S POLICY GROUP OR POLY NUMBER	
10. EMPLOYMENT (Current or Former)		11. INSURED'S DATE OF BIRTH MM DD YY SEX	
12. AUTO ACCIDENT? PLACE (State)		13. OTHER CLAIM? (Designated by NUCC)	
14. OTHER ADD-DONE? YES NO		15. INSURANCE PLAN NAME OR PROGRAM NAME	
16. CLAIM CODES (Designated by NUCC)		17. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 18, 19, 20 & 21)	
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 or government credits other to myself or to the party who accepts assigned claim.		19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described herein.	
20. DATE		21. SIGNED	
22. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED		23. OTHER DATE	
24. NAME OF REFERRING PROVIDER OR OTHER SOURCE		25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		27. OUTSIDE LABOR CHARGES	
28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below)		29. PHYSICIAN ORDER ORIGINAL REF. NO.	
30. PRIOR AUTHORIZATION NUMBER		31. PHYSICIAN OR SUPPLIER INFORMATION	
32. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER (CPT/HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. PAYOR G. PAYOR ID. QUAL. H. PROVIDING PROVIDER ID #		33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR OFFICE (If bills for the claim are to be rendered apply to the bill and not to this part thereof.)	
34. PATIENT'S ACCOUNT NO.		35. SERVICE FACILITY LOCATION INFORMATION	
36. TOTAL CHARGE		37. 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 MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN IS OR WAS COVERED BY OTHER
 Medicare Medicaid Tricare Medicare Other Other Other 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 (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 Section 9a, 9b, and 9c)
 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. DATE (MM DD YY) SIGNED

18. DATE OF CURRENT SURGICAL INJURY, IF PREVIOUSLY LISTED (MM DD YY) QUAL ()
 19. CENSUS DATE (MM DD YY)
 20. DATE (MM DD YY) NAME (Last Name, First Name, Middle Initial) OCCUPATION ()
 21. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MM DD YY) ()
 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) ()
 23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 24. OUTSIDE CLAIM # ()
 25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events/conditions/diagnoses)
 A. () B. () C. () D. ()
 E. () F. () G. () H. ()
 I. () J. () K. () L. ()
 26. ICD-9-CM CODE () ORIGINAL REF # ()
 27. PRIOR AUTHORIZATION NUMBER ()

28. A. DATE OF SERVICE	B. FROM	C. TO	D. PLACE OF SERVICE	E. PROVIDER, SUPPLIER, OR SUPPLIER	F. DIAGNOSIS	G. CHARGE	H. ICD-9-CM CODE	I. REFERRING PROVIDER'S QUAL.	J. REFERRING PROVIDER'S #
MM DD YY	MM DD YY	MM DD YY	PLACE OF SERVICE	Physician, Nurse, Osteopath, Podiatrist, Chiropractor, Optometrist, Other	ICD-9-CM CODE	\$ CHARGE	ICD-9-CM CODE	QUAL.	PROVIDER'S #
1								NP1	
2								NP1	
3								NP1	
4								NP1	
5								NP1	
6								NP1	

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

35. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the diagnosis or procedure apply to the bill and on which a bill is sent))
 36. SERVICE FACILITY LOCATION INFORMATION
 37. 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	Enter the insured's group or plan number
			SR033	Insured group or policy 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 CHAMPVA OTHER HEALTH PLAN SELA (BY LINE) OTHER

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

3. PATIENT'S ADDRESS (No. Street)

4. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)

5. PATIENT'S RELATIONSHIP TO INSURED

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

7. INSURED'S ADDRESS (No. Street)

8. RESERVED FOR FUTURE USE

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

10. IS PATIENT'S CONDITION RELATED TO:

11. RESERVED FOR FUTURE USE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. OTHER INSURED'S POLICY OR GROUP NUMBER

14. DATE OF CLAIM (MM DD YY)

15. OTHER DATE (MM DD YY)

16. DATE OF SERVICE (From To)

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 ICD-9-CM codes below)

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

21. OUTSIDE LAB

22. PRIORITY AUTHORIZATION NUMBER

23. FEDERAL TAX ID NUMBER

24. PATIENT'S ACCOUNT NO.

25. ACCENT ASSIGNMENT?

26. TOTAL CHARGE

27. PAYMENT PAID

28. SERVICE FACILITY LOCATION INFORMATION

29. BILLING PROVIDER INFO & P#

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

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 PLAN (OHP) 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. INSURED'S POLICY GROUP OR POLICY NUMBER

8. EMPLOYMENT (Current or Previous)

9. INSURED'S DATE OF BIRTH (MM, DD, YY)

10. OTHER CLAIMS (Designated by NUCC)

11. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMATIC CLAIM

14. OTHER DATE

15. DATE OF SERVICE (FROM, TO)

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE (FROM, TO)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

20. OFFICE LAMP

21. PHYSICIAN CODE

22. PRIOR AUTHORIZATION NUMBER

23. FEDERAL TAX ID NUMBER

24. PATIENT'S ACCOUNT NO.

25. ACCOUNT ASSIGNMENT?

26. TOTAL CHARGE

27. AMOUNT PAID

28. BILLING PROVIDER INFO (Name, Address, City, STATE, ZIP CODE)

29. SERVICE FACILITY LOCATION INFORMATION

30. BILLING PROVIDER INFO (Name, Address, City, STATE, ZIP CODE)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO (Name, Address, City, STATE, ZIP CODE)

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)

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

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. PHYSICIAN IDENTIFICATION NUMBER E. CHARGE 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 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 OFFICE ADDRESS (If both the insurer and the provider apply to the 31 and are on a bill a 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	Claim submitter's identifier	
			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 (MR, MRS, MS, 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 (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. EMPLOYMENT (Current or Former) (YES, NO) PLACE (State)
 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) \$ CHARGES
 21. 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)
 22. REFERRAL OR REF ID
 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. PROVIDING PROVIDER ID #
 25. FEDERAL TAX ID NUMBER
 26. PATIENT'S ACCOUNT NO.
 27. ASSIGNMENT? (YES, NO)
 28. TOTAL CHARGE \$
 29. AMOUNT PAID \$
 30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials. If entity that this claim is for, no charges apply to the SE and SE with a self-render.)
 31. SERVICE FACILITY LOCATION INFORMATION
 32. BILLING PROVIDER INFO & PIN# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

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 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 MUCC USE CITY STATE

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

8. 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 10. EMPLOYMENT (Current or Former) 11. INSURED'S DATE OF BIRTH SEX

5. RESERVED FOR MUCC USE 10. AUTO ACCIDENT? PLACE (State) 11. OTHER CLAIMS (Designated by MUCC)

6. RESERVED FOR MUCC USE 10. OTHER ACCIDENT? 11. INSURANCE PLAN NAME OR PROGRAM NAME

8. INSURANCE PLAN NAME OR PROGRAM NAME 10. CLAIM CODES (Designated by MUCC) 11. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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 assignment below.

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 PREVIOUSLY CLAIMED 15. OTHER DATE 16. OTHER (Last Name, First Name, Middle Initial) OCCUPATION

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

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 20. OUTSIDE LAMP 21. CHANGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below) 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 SUPPLY D. DIAGNOSIS E. CHARGE F. ICD-9-CM G. ICD-9-CM H. NONCOVERING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (Only if the claim is to be assigned apply to the 31 and set it with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

PHYSICIAN OR SUPPLIER INFORMATION

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 3/00/0012

1. MEDICARE MEDICAID TRICARE CHAMPVA GEHAIP HEALTH PLAN SEVERE ILLNESS OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S ADDRESS (No. Street)
 CITY STATE ZIP CODE TELEPHONE (provide Area Code)

4. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
 5. PATIENT RELATIONSHIP TO INSURED
 6. RESERVED FOR FUTURE USE

7. INSURED'S ADDRESS (No. Street)
 CITY STATE ZIP CODE TELEPHONE (provide 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) YES NO
 B. AUTO ACCIDENT? PLACE (State) YES NO
 C. OTHER ACCIDENT? YES NO
 D. CLAIM CODES (Designated by NCCI)

11. INSURED'S POLICY OR GROUP OR POLICY NUMBER
 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)
 13. OTHER CLAIM ID (One granted by NCCI)
 14. INSURANCE PLAN NAME OR PROGRAM NAME
 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete item 16, 17, 18)

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

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

18. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

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

20. PHYSICIAN OR SUPPLIER INFORMATION
 21. PRIOR AUTHORIZATION NUMBER

22. FEDERAL TAX ID NUMBER SSN EIN PATIENT'S ACCOUNT NO. COORDINATION BENEFIT ASSIGNMENT? YES NO TOTAL CHARGE AMOUNT PAID
 23. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials if apply. If at the claim level, this element applies to the bill and not to each a part benefit.) SERVICE FACILITY LOCATION INFORMATION BILLING PROVIDER INFO & PII#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

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 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 (Designated by NCCI)		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. PHYSICIAN OR SUPPLIER E. CHARGE F. DATE OF SERVICE G. CHARGE H. CHARGE I. CHARGE J. CHARGE		19. PHYSICIAN OR SUPPLIER INFORMATION	
21. SIGNATURE OF PHYSICIAN OR SUPPLIER		20. PHYSICIAN OR SUPPLIER INFORMATION	
22. SERVICE FACILITY LOCATION INFORMATION		21. PHYSICIAN OR SUPPLIER INFORMATION	
23. BILLING PROVIDER INFO & PAY ()		22. 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 (NUCC) 0012

PCIA []

1. MEDICARE [] MEDICAID [] TRICARE [] CHIP/STAP [] GROUP HEALTH PLAN [] SELF OR INDIVIDUAL [] OTHER []

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

3. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (provide area code)

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

5. PATIENT RELATIONSHIP TO INSURED

6. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (provide area code)

7. IS THIS PHYSICIAN'S CONDITION RELATED TO

8. EMPLOYMENT (Date of Pre-Event)

9. AUTO ACCIDENT? PLACE (State)

10. OTHER ACCIDENT?

11. INSURED'S POLICY OR GROUP OR FICA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authenticate the release of any medical or other information necessary to process this claim. Also request payment of government credits after 90 days if to the party who accepts assignment claim.)

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?

14. DATE OF LARGEST SURGICAL INJURY OR PHYSICIAN'S LAST VISIT (Other Date) MM DD YY QUAL. MM

15. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

18. DIAGNOSIS OF NATURE OF CLARIFY OF INJURY (Name of Condition with ICD-9 CODE) A B C D E F G H I J

19. PHYSICIAN OR SUPPLIER INFORMATION

20. FEDERAL TAX ID NUMBER

21. PATIENT'S ACCOUNT NO.

22. TOTAL CHARGE \$

23. SERVICE FACILITY LOCATION INFORMATION

24. BILLING PROVIDER INFO & PRN# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR 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)	
3. PATIENT'S BIRTH DATE MM DD YY SEX		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. INSURED'S ADDRESS (No. Street)	
6. PATIENT RELATIONSHIP TO INSURED		9. INSURED'S POLICY GROUP OR POLICY NUMBER	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S DATE OF BIRTH MM DD YY SEX	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		22. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE		25. FEDERAL TAX ID NUMBER	
26. PATIENT'S ACCOUNT NO.		27. ACCOUNT ASSIGNMENT?	
28. SIGNATURE OF PHYSICIAN OR SUPPLIER		29. TOTAL CHARGE	
30. SERVICE FACILITY LOCATION INFORMATION		31. 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	



PCIA

1. 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

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 PRESENTLY CLAIM

15. OTHER DATE

16. DATE OF BIRTH AND NUMBER OF WORK-RELATED OCCUPATIONAL INJURY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. HOSPITALIZATION CODE

22. PRIOR AUTHORIZATION NUMBER

23. A. CARRIER OF SERVICE B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER D. DIAGNOSIS E. CHARGE F. DATE OF SERVICE G. H. I. J. K. L.

24. FEDERAL TAX ID NUMBER

25. PATIENT'S ACCOUNT NO.

26. ACCOUNT ASSIGNMENT?

27. TOTAL CHARGE

28. AMOUNT PAID

29. PROVIDER SIGNATURE

30. SERVICE FACILITY LOCATION INFORMATION

31. 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 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 PATIENT'S CONDITION RELATED TO 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 assignment below.) 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 14, 15, and 16.)

14. DATE OF CURRENT SERVICE, INJURY, OR PROGRAMMATIC CLAIM (MM DD YY) QUAL 15. CLAIM DATE (MM DD YY) 16. DATE OF LAST WORKING OCCUPATION (MM DD YY) FROM TO

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP 21. PRIOR AUTHORIZATION NUMBER

22. FEDERAL TAX ID NUMBER 23. PATIENT'S ACCOUNT NO. 24. ACCOUNT ASSIGNMENT? YES NO 25. TOTAL CHARGE \$ 26. AMOUNT PAID \$ 27. NUMBER NUCC USE

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that the information is correct apply to the SE and use with a post office)) 29. SERVICE FACILITY LOCATION INFORMATION 30. 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 SELF OR OTHER OTHER (For Program in Item 1)

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 Former)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (Designated by NUCC)

18. INSURANCE PLAN NAME OR PROGRAM NAME

19. IS THERE ANOTHER HEALTH BENEFIT PLAN?

20. OUTSIDE LAB? YES NO \$ CHARGES

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

22. OTHER DATE (MM DD YY)

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 latest ICD-9-CM)

26. FEDERAL TAX ID NUMBER

27. PATIENT'S ACCOUNT NO.

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials to certify that the statements on this form apply to this bill and are in whole or part correct)

29. SERVICE FACILITY LOCATION INFORMATION

30. BILLING PROVIDER INFO & P# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN DECA/DCO 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)	
3. PATIENT'S BIRTH DATE MM DD YY SEX		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. CITY STATE ZIP CODE TELEPHONE (Area Code)	
6. PATIENT RELATIONSHIP TO INSURED		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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
18. ADDITIONAL CLAIM INFORMATION		19. OUTSIDE LAB	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))		20. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.	
28. SIGNATURE OF PHYSICIAN OR SUPPLIER		29. TOTAL CHARGE	
30. SERVICE FACILITY LOCATION INFORMATION		31. 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 INDIVIDUAL 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 Self Spouse Child Other

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

7. IS THIS CLAIM FOR NUCC USE? YES NO

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: YES NO

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 paid to the party who accepts assignment below.)

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMED CLARITY 15. CERTAIN DATE

16. DATE OF BIRTH (MM/DD/YYYY) SEX M F

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP YES NO

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. A. DATE OF SERVICE B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLY D. DIAGNOSIS

24. FEDERAL TAX ID NUMBER 25. PATIENT'S ACCOUNT NO. 26. TOTAL CHARGE 27. ACCOUNT ASSIGNMENT? YES NO

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (I certify that this statement of business applies to the bill and on behalf of patient))

29. SERVICE FACILITY LOCATION INFORMATION

30. BILLING PROVIDER INFO & PRF

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 PREVIOUSLY CLAIM		16. OTHER DATE (QUAL MM DD YY)	
14. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
15. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)		18. OUTSIDE CLAIM # (CHANGES)	
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	

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

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

12. OTHER INSURED'S POLICY OR GROUP NUMBER 13. EMPLOYMENT (Current or Former) 14. INSURED'S DATE OF BIRTH MM DD YY SEX

15. RESERVED FOR NUCC USE 16. AUTO ACCIDENT? PLACE (State) 17. OTHER CLAIM? (Designated by NUCC) 18. INSURANCE PLAN NAME OR PROGRAM NAME

19. RESERVED FOR NUCC USE 20. OTHER ACCIDENT? 21. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 14, 15, 16, 17, 18, 19, 20, 21)

22. 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 assigned claim. 23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described herein.

SIGNED DATE SIGNED

24. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 25. OTHER DATE QUAL MM DD YY 26. DATES OF AND NUMBER OF WORK-RELATED OCCUPATIONAL INJURY FROM TO OCCUPATION

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 LABOR CHARGES YES NO

31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 12 months) 32. PHYSICIAN CODE ORIGINAL REF NO

33. PRIOR AUTHORIZATION NUMBER

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

LINE	DATE OF SERVICE	PLACE OF SERVICE	CPT/HCPCS	MODIFIER(S)	DIAGNOSIS CODE	CHARGE/UNIT	UNITS	RENDERING/PERFORMING PHYSICIAN OR NPP
1								
2								
3								
4								
5								
6								

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-EMPLOYED 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 CLAIM CODES (Designated by NCCI)

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 14, 15, 16, 17, 18)

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

15. OTHER DATE

16. DATE OF LAST WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN EIN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

20. OUTSIDE LAMP

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

22. PHYSICIAN ORDER

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER D. DIAGNOSIS E. CHARGE F. ICD-9-CM G. REFERRING PROVIDER ID #

25. FEDERAL TAX ID. NUMBER SSN EIN

26. ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. REVIEW NUCUC 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 INDIVIDUAL 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 PROGRAMMED CARE (MM/DD/YY)

15. CLAIM DATE (MM/DD/YY)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP

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

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 (012)

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

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

3. PATIENT'S BIRTH DATE SEX

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PRESENT CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. IS THIS ANOTHER HEALTH BENEFIT PLAN? YES NO

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 than to myself to the party who accepts assignment below.)

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

15. OTHER DATE QUAL. MM DD YY

16. DATE OF BIRTH AND NUMBER OF WORK-RELATED OCCUPATIONAL INJURY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN 17A 17B 17C

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. OUTSIDE LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all events in the last 12 months)

22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE	B. PLACE OF SERVICE	C. PROCEDURE, SERVICE, OR SUPPLY	D. DIAGNOSIS	E. CHARGES	F. PAYOR	G. AMOUNT PAID	H. C. CODE	I. NONCLAIM PROVIDER ID #
MM DD YY	MM DD YY	ICD-9-CM	ICD-9-CM					
1							NP1	
2							NP1	
3							NP1	
4							NP1	
5							NP1	
6							NP1	

25. FEDERAL TAX ID NUMBER SSN ID#

26. PATIENT'S ACCOUNT #

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. FINDER'S FEE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the charges to be billed apply to the patient and are in compliance with applicable laws.)

32. SERVICE FACILITY LOCATION (If applicable)

33. BILLING PROVIDER INFO & PAY ()

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 ISOR (OR OTHER) (For Program in Item 1)

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

3. PATIENT'S ADDRESS (No. Street)

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

5. PATIENT'S RELATIONSHIP TO INSURED

6. INSURED'S ADDRESS (No. Street)

7. INSURED'S POLICY OR GROUP OR FICA NUMBER

8. INSURED'S DATE OF BIRTH

9. OTHER CLAIM ID (Designated by NUCC)

10. INSURANCE PLAN NAME OR PROGRAM NAME

11. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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 credits due to myself or to the party whose assignment is shown below.)

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

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

15. CLAIM DATE

16. DATE (or DATE RANGE) WHEN 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 LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events/active below) (ICD-9-CM)

22. REFERRAL CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. PROCEDURE, SUPPLIER, OR SUPPLIER PLACE OF SERVICE C. DIAGNOSIS, ICD-9-CM D. PROVIDER IDENTIFICATION E. CHARGES F. DATE OF SERVICE G. REF. NO. H. QUAL. I. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN (or EIN)

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 apply to the claim or to the claims apply to the claim and on train a part below)

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

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 payment 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 authorized physician or supplier for services described below.)

SIGNED DATE SIGNED

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 LAB? \$ CHARGE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 12 months) 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. CHARGE F. ICD-9-CM G. PROVIDER H. NONCOVER PROVIDER 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? YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESUBMIT

31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PAY ()

SIGNED DATE

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 PCA

1. MEDICARE MEDICAID TRICARE CHIP/STAA 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. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PHYSICIAN'S CONDITION RELATED TO YES NO

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

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

15. OTHER DATE (MM/DD/YY)

16. DATE OF BIRTH (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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 (Name, AC, Enter the later ICD-9)

22. HPSA MARKING CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (From/To)

25. FEDERAL TAX ID NUMBER

26. SIGNATURE OF PHYSICIAN OR SUPPLIER

27. SERVICE FACILITY LOCATION INFORMATION

28. TOTAL CHARGE

29. AMOUNT PAID

30. BILLING PROVIDER INFO & PH#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

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 (M, F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (MR, MRS, MISS, MS, DR, OTHER) 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 (a) EMPLOYMENT (Current or Former) (b) AUTO ACCIDENT? (c) OTHER ACCIDENT? 11. INSURED'S POLICY GROUP OR FICA NUMBER 12. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F) 13. OTHER CLAIMS (Prepaid by FICA) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES, NO) (If yes, complete Form 9, 9a, 9b, 9c) 16. 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.) 17. DATE 18. SIGNED 19. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM, DD, YY) 20. OTHER DATE (MM, DD, YY) 21. ORDER OF SERVICE (FROM, TO) 22. WORK IN CURRENT OCCUPATION (FROM, TO) 23. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO) 24. OUTSIDE LABOR (YES, NO) 25. PHYSICIAN OR SUPPLIER 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) 26. A. CARRIER OF SERVICE (FROM, TO) B. PLACE OF SERVICE (CITY, STATE, ZIP) C. PROCEDURE, SERVICE, OR SUPPLIER (CPT/HCPCS) D. PHYSICIAN IDENTIFICATION NUMBER E. CHARGE F. AMOUNT PAID G. FICA NUMBER H. IDENTIFICATION NUMBER I. IDENTIFICATION NUMBER J. IDENTIFICATION NUMBER K. IDENTIFICATION NUMBER L. IDENTIFICATION NUMBER M. IDENTIFICATION NUMBER N. IDENTIFICATION NUMBER O. IDENTIFICATION NUMBER P. IDENTIFICATION NUMBER Q. IDENTIFICATION NUMBER R. IDENTIFICATION NUMBER S. IDENTIFICATION NUMBER T. IDENTIFICATION NUMBER U. IDENTIFICATION NUMBER V. IDENTIFICATION NUMBER W. IDENTIFICATION NUMBER X. IDENTIFICATION NUMBER Y. IDENTIFICATION NUMBER Z. IDENTIFICATION NUMBER

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	2310C	NM109 (ZZ)	Laboratory/Facility Primary Identifier	Enter the NPI of the Service Facility. Enter "XX" in the NM106 to indicate the NPI is present in the NM108.
		2400C**	NM109 (ZZ)	Purchased service provider identifier	
		2400	PS101	Purchased service provider identifier	
		2420U	NM101	Identification code qualifier =00	
		2300	NM106	Identification code	
			NM101	Identification code qualifier =0R	
			NM108	Identification code	
			NM109	Identification code	
			REF01	Reference Identification qualifier =0W	
			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 FUTURE USE 9. RESERVED FOR FUTURE USE 10. RESERVED FOR FUTURE 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. INSURED'S DATE OF BIRTH SEX 14. OTHER CLAIM ID (as designated by NUCC) 15. INSURANCE PLAN NAME OR PROGRAM NAME 16. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) (If yes, complete Item 9, 10, and 11.)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. DATE OF SERVICE FROM TO 19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO 20. OUTSIDE LAB? (Yes/No) 21. PRELIMINARY CODE (ORIGINAL PIP NO) 22. PRIOR AUTHORIZATION NUMBER

23. BILLING PROVIDER INFO & P1 ()

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](#)

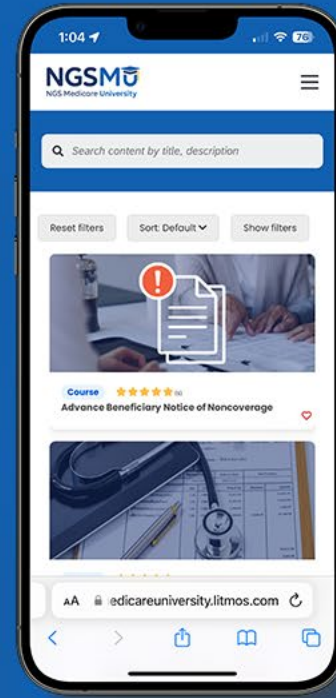
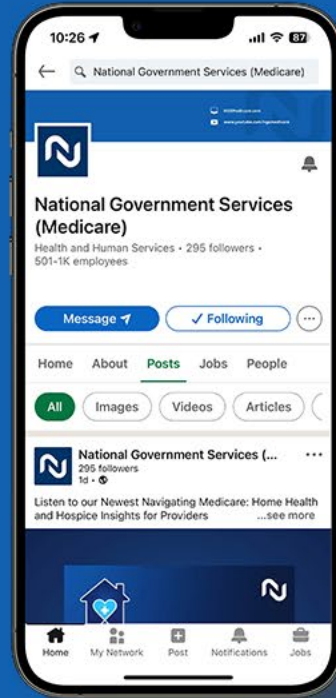
Resources, References and Tools

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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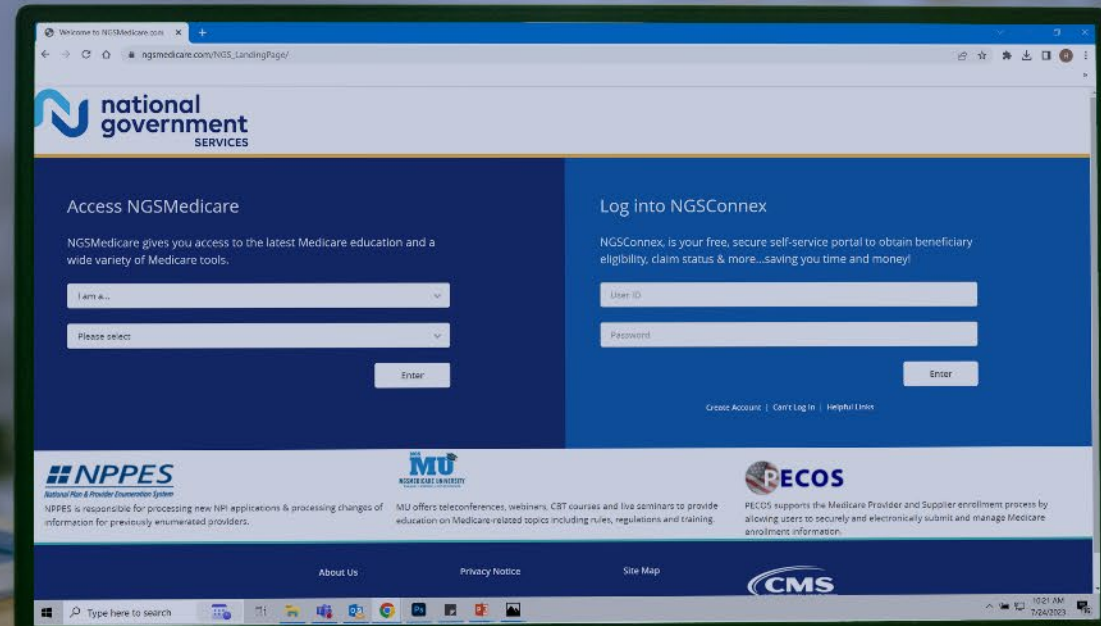


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