

# Proper Part B Claim Submissions

9/12/2024

**Closed Captioning:** *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

# Today's Presenters

Provider Outreach and  
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# Objective

After completion attendees will be able to

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



# Agenda

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

# Claim Form Requirements

# Claim Submission Requirements

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



# ASCA Regulations

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



# Time Limits for Filing Medicare Claims

# Claim Filing Time Limits

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



# Claim Form Overview

# CMS-1500 Claim Form (02/12)

The diagram shows a CMS-1500 Health Insurance Claim Form with two yellow arrows pointing to specific sections. The first arrow, labeled "Beneficiary data", points to the top section of the form, which includes fields for patient name, address, date of birth, sex, and insurance information. The second arrow, labeled "Provider data", points to the bottom section of the form, which includes fields for provider name, address, and contact information. A red horizontal line is drawn across the middle of the form, separating the beneficiary information from the provider 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 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  
 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 Inial) 10. IS PATIENT'S CONDITION RELATED TO:  YES  NO  
 9. OTHER INSURED'S POLICY OR GROUP NUMBER 11. INSURED'S POLICY GROUP OR FECA 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 either to myself or to the party who accepts assignment below.)

14. DATE OF CURRENT SURVIVAL SURVEY, IF PRESUMPTIVE CLAIM 15. OTHER DATE: QUAL. MM DD YY  
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  
 21. DIAGNOSIS OR NATURE OF ILLNESS OF ACCIDENT (Provide ALL events in the below ICD-9-CM) A. B. C. D. E. F. G. H. I. J. K. L.  
 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO  
 23. OUTPATIENT CHARGES: YES NO

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 1

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

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

# Line Item 1a

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

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

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

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

**PATIENT AND INSURED INFORMATION**

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

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

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

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

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

8. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO 9. IS THIS ANOTHER HEALTH BENEFIT PLAN? YES NO

10. IS THIS ANOTHER HEALTH BENEFIT PLAN? YES NO

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

12. PATIENTS OR AUTHORIZED PERSONS 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.) SIGNED DATE

13. PATIENTS OR AUTHORIZED PERSONS 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.) SIGNED DATE

14. DATE OF CURRENT SURGICAL INJURY, OR PROSPECTIVE DATE (MM DD YY) QUAL (A, B, C, D, E, F, G, H, I, J, K, L) 15. LENGTH DATE (MM DD YY)

16. DATE (MM DD YY) HOURS (MM DD YY) OCCUPATION (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SN 179 NR) 18. HOSPITAL/CATCH DATES RELATED TO CURRENT SERVICES (MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events that have been diagnosed) A. B. C. D. E. F. G. H. I. J. K. L.

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

24. A. DATE OF SERVICE (From To) B. PLACE OF SERVICE (C, D, E, F, G, H, I, J, K, L) C. PROCEDURE, ICD-9-CM OR SUPPLIER (C, D, E, F, G, H, I, J, K, L) D. DIAGNOSIS (ICD-9-CM) 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 (SN SN) 26. PATIENT'S ACCOUNT NO. 27. ACCIDENT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REBIL/MUO/UM

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE OR CREDENTIALS (I certify that the signature on this document applies to the bill and on trade a part thereof)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ( )

**PHYSICIAN OR SUPPLIER INFORMATION**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

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

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

3. PATIENT'S ADDRESS INC. STATE

4. CITY STATE

5. RECEIVED FOR NUCC USE

6. CITY STATE

7. ZIP CODE TELEPHONE (include area code)

8. ZIP CODE TELEPHONE (include area code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CLAIM (month, day, year)

15. OTHER DATE (month, day, year)

16. DATE (month, day, year)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY

22. HEBEL-BERSON CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER OR SUPPLIER (Origin, Unk, Other) D. DIAGNOSIS FOR ICD-9 E. CHARGES F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

25. FEDERAL TAX ID NUMBER SSN GN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REMAINING NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

# Line Item 2

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

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



# Line Item 3

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

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

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

1. MEDICARE MEDICAID TRICARE CHIP/STP SEEMP HEALTH PLAN IS/OB SEX (LINE) OTHER 1a. INSURED'S ID NUMBER (For Program in Item 1)

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

5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 6. OTHER INSURED'S POLICY OR GROUP NUMBER 7. EMPLOYMENT (Check or Print) YES NO 8. AUTO ACCIDENT? YES NO 9. OTHER ACCIDENT? YES NO 10. CLAIM CODES (Designated by NUCC)

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

14. DATE OF CLAIMED SURVIVAL, INJURY, OR PROGRAMMY (MM DD YY) QUAL. 15. OTHER DATE (MM DD YY) QUAL. 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? 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 C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS E. CHARGES F. PAYOR G. ID. CL. H. PROVIDER

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this claim apply to this bill and are made in good faith.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & Pmt ( )

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

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

3. PATIENT'S BIRTH DATE

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

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

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS THIS EMPLOYER-RELATED TO THIS EMPLOYMENT (Current or Former)

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. IS THIS EMPLOYER-RELATED TO THIS EMPLOYMENT (Current or Former)

13. INSURED'S DATE OF BIRTH

14. STATE OF CURRENT RESIDENCE (If Permanently Disabled)

15. OTHER DATE

16. DATE OF LAST WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. OUTSIDE LABOR CHARGES

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

22. PHYSICIAN OR SUPPLIER INFORMATION

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS E. CHARGES F. PAY RATE G. PAY PERIOD H. PROVIDING PHYSICIAN I. #

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. REVIEW NUGO 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 GEOPOLITICAL PLAN SGLV (SGL) OTHER (For Program in Item 1)

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

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

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

5. PATIENT'S ADDRESS (No., Street)

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

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

8. EMPLOYMENT (Current or Pending) YES/NO

9. AUTO ACCIDENT? YES/NO

10. OTHER ACCIDENT? YES/NO

11. INSURED'S POLICY OR 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 Medicare to the party who accepts assignment.)

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

14. DATE OF CURRENT SERVICE INJURY OR PREGNANCY CLAIM

15. OTHER DATE

16. DATE PATIENT CAME TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

19. OUTSIDE LAB? YES/NO

20. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Nails AL, External or Internal) (ICD-9-CM)

21. PRIOR AUTHORIZATION NUMBER

22. A. DATES OF SERVICE FROM TO PLACE OF SERVICE (ICD-9-CM) B. PROCEDURE, SUPPLY OR SERVICE (ICD-9-CM) C. DIAGNOSIS POSITION D. CHARGE E. CHARGE F. RATE OF BENEFIT G. UNIT OF SERVICE H. QUANTITY I. RECEIVING PROVIDER ID #

23. FEDERAL TAX ID NUMBER SSN EIN

24. PATIENT'S ACCOUNT NO. IF ACCOUNT ASSIGNMENT? YES/NO

25. TOTAL CHARGE \$ 26. AMOUNT PAID \$ 27. REMITTED TO DATE

28. 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.)

29. SERVICE FACILITY LOCATION INFORMATION

30. BILLING PROVIDER INFO & PRF ( )

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

6. OTHER INSURED'S POLICY OR GROUP NUMBER 12. EMPLOYMENT (Current or Former) 12.1 YES 12.2 NO 12.3 PLACE (State)

7. RESERVED FOR NUCC USE 13. AUTO ACCIDENT? 13.1 YES 13.2 NO 13.3 PLACE (State)

8. RESERVED FOR NUCC USE 14. OTHER ACCIDENT? 14.1 YES 14.2 NO 14.3 PLACE (State)

9. INSURANCE PLAN NAME OR PROGRAM NAME 15. CLAIM CODES (Designated by NUCC) 16. IS THERE ANOTHER HEALTH BENEFIT PLAN? 16.1 YES 16.2 NO (If yes, complete Item 9, 10, and 11)

17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits either to myself or to the party who accepts assigned claim.) 18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

19. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 20. OTHER DATE 21. OTHER DATE

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

24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 25. OUTSIDE LAMP 25.1 YES 25.2 NO 25.3 CHANGES

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9 code and date when diagnosed) 27. PHYSICIAN CODE 27.1 ORIGINAL REF. NO. 27.2 PRIOR AUTHORIZATION NUMBER

28. A. DATE OF SERVICE FROM TO B. C. D. PROVIDER, SUPPLIER, OR SUPPLIER B. DIAGNOSIS 28.1 CHANGES 28.2 ICD-9-CM 28.3 ICD-9-CM 28.4 ICD-9-CM 28.5 ICD-9-CM 28.6 ICD-9-CM 28.7 ICD-9-CM 28.8 ICD-9-CM 28.9 ICD-9-CM 28.0 ICD-9-CM

29. FEDERAL TAX ID NUMBER 30. PATIENT'S ACCOUNT NO. 31. ACCOUNT ASSIGNMENT? 32. TOTAL CHARGE 33. AMOUNT PAID 34. RESERVED FOR NUCC USE

35. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include credentials or credentials of entity that the claim is for. Do not include apply to the SE and use with a part benefit.) 36. SERVICE FACILITY LOCATION INFORMATION 37. BILLING PROVIDER INFO & PAY ( )

# Line Item 6

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

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

# Line Item 7

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

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

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

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

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

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

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

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than just D to the party who accepts assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) (A / B / C / D / E / F / G / H / I / J / K / L) 22. PREVIOUS WORKER CODE ORIGINAL EMP. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CATEGORY OF SERVICE (MM / DD / YY) ( ) B. PLACE OF SERVICE ( ) C. PROCEDURE, SERVICE, OR SUPPLY ( ) D. DIAGNOSIS ( ) E. CHARGES ( ) F. AMOUNT PAID ( ) G. NUMBER OF SERVICES ( ) H. PROVIDER NUMBER ( )

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER ( ) 32. SERVICE FACILITY LOCATION INFORMATION ( ) 33. BILLING PROVIDER INFO & PAYER ( )

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR SPOUSE OTHER		14. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
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 POLICY NUMBER	
10. EMPLOYMENT (Current or Former)		11. INSURED'S DATE OF BIRTH MM DD YY SEX	
12. AUTO ACCIDENT? YES NO 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 below.	
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		29. PHYSICIAN ORDER ORIGINAL REF. NO.	
30. PRIOR AUTHORIZATION NUMBER			
31. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS		32. P. CHARGES Q. RATE R. UNIT S. TIME T. QUANTITY U. PROVIDING PROVIDER ID #	
33. FEDERAL TAX ID NUMBER		34. PATIENT'S ACCOUNT NO.	
35. SIGNATURE OF PHYSICIAN OR SUPPLIER		36. SERVICE FACILITY LOCATION INFORMATION	
37. TOTAL CHARGE		38. 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 MEDIGAP TRICARE CHAMPVA GROUP HEALTH PLAN IS OR WAS COVERED BY OTHER  
 MEDICARE  MEDIGAP  TRICARE  CHAMPVA  GROUP HEALTH PLAN  IS OR WAS COVERED BY OTHER

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)  
 5. INSURED'S ADDRESS (No. Street)  
 CITY STATE ZIP CODE TELEPHONE (Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED  
 Self  Spouse  Child  Other

7. INSURED'S POLICY OR GROUP OR FEDCA NUMBER

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

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. ALSO ACCIDENT? PLACE (Date)  YES  NO  
 c. OTHER ACCIDENT?  YES  NO  
 10a. CLAIM CODES (Designated by NUCC)

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

12. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include the address of any medical or other information necessary to process the claim. I also request payment of government credits other to myself or to the party whose name is assigned below.)  
 SIGNED: DATE: SIGNED: DATE:

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

14. DATE OF CURRENT SURVIVAL SURVEY, IF PREVIOUSLY DONE (MM DD YY) QUAL ( )

15. LENGTH DATE (MM DD YY) QUAL ( )

16. DATE (MM DD YY) NAME ( ) WORK OR CURRENT OCCUPATION ( )

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE ( )

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES ( )

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?  YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify ALL events that have been done ACCIDENTS)  
 A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_  
 E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_  
 I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

22. PRESCRIPTION CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER

24. A. CATALOG OF SERVICES From To B. PLACE OF SERVICE C. PROVIDER, SUPPLIER OR SUPPLIER (Specify Unique Organization Identifier) D. DIAGNOSIS HICSDRUG POLYMERIC E. CHARGES F. ICD-9-CM G. ICD-9-CM H. ICD-9-CM I. ICD-9-CM J. ICD-9-CM K. ICD-9-CM L. ICD-9-CM

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCIDENT ASSIGNMENT? (YES NO)

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. FEES BY NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the signature on this claim applies to the bill and on trade a part thereof))

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH# ( )

# 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	3330A	NM103	Other insured last name	Name of insured for Medigap plan
	Name (Last, First,		NM104	Other insured first name	
	Middle Initial)		NM105	Other insured middle name	
9a*	Other insured's policy or group number (Medigap only)	3330A	NM106	Identification Code Qualifier (MI Member Ident. Station Number)	Medigap policy ID
			NM108	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 REV (LINE) OTHER

2. PATIENT'S NAME, LAST NAME, FIRST NAME, MIDDLE NAME

3. PATIENT'S BIRTH DATE

4. INSURED'S NAME, LAST NAME, FIRST NAME, MIDDLE NAME

5. PATIENT'S ADDRESS (incl. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (incl. Street)

8. RESERVED FOR FUTURE USE

9. OTHER INSURED'S NAME, LAST NAME, FIRST NAME, MIDDLE NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. OTHER INSURED'S POLICY OR GROUP NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. DATE OF SERVICE

14. DATE OF CLAIM

15. OTHER DATE

16. DATE OF SERVICE

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

20. HOSPITALIZATION DATES

21. OUTSIDE LAB

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE, B. PLACE OF SERVICE, C. PROCEDURE, SERVICE, OR SUPPLY, D. DIAGNOSIS, PORTAL, E. CHARGE, F. CHARGE, G. CHARGE, H. CHARGE, I. CHARGE, J. CHARGE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. PAYEE NUMBER

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. 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 (Specify)

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 RELATIONSHIP TO INSURED

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

7. INSURED'S POLICY GROUP OR POLICY NUMBER

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

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

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

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (If patient is over 18, also require payment of government contribution to group or to the party who made assignment)

13. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMATIC CLAIM (MM, DD, YY)

14. OTHER DATE (MM, DD, YY)

15. DATE OF SERVICE (FROM, TO)

16. DATE OF SERVICE (FROM, TO)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP (YES, NO)

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

22. HIRING NUMBER (CODE)

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE (FROM, TO) B. PLACE OF SERVICE (ICD-9-CM) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGE (ICD-9-CM) F. CHARGE (ICD-9-CM) G. CHARGE (ICD-9-CM) H. CHARGE (ICD-9-CM) I. CHARGE (ICD-9-CM) J. CHARGE (ICD-9-CM)

25. FEDERAL TAX ID NUMBER (SSN EIN)

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT? (YES, NO)

28. TOTAL CHARGE (\$)

29. AMOUNT PAID (\$)

30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that the claimant or his/her agent is the M and on with a part B carrier))

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & Pmt# ( )

10d. CLAIM CODES (Designated by NUCC)

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

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

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

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

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

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

11b. OTHER CLAIM ID (Designated by NUCC)

11c. INSURANCE PLAN NAME OR PROGRAM NAME

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits either to myself or to the party who accepts assigned claim.

13. DATE SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE QUAL. 16. DATE OF BIRTH AND NUMBER OF YEARS 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 LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL applicable 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 Other) D. PHYSICIAN CODE E. CHARGES F. PAY RATE G. PAY PERCENT H. ID. QUAL. I. PROVIDING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (If bills to the insurer or to a reinsurer apply to the 30 and set it with a post office) 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 <b>*Note:</b> 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 (M, W, C, O, OTH)  
 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 (Y, N)  
 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 either to myself or to the party who accepts assignment below.  
 SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
 13. EMPLOYMENT (Current or Former) (Y, N)  
 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? (Y, N)  
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events relative to this claim)  
 22. REFERRAL NUMBER ORIGINAL REF NO.  
 23. PRIOR AUTHORIZATION NUMBER  
 24. A. DATES OF SERVICE (From, To) B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Special, License, Organization, Membership) 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 SSN (IN) 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (Y, N) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REVENUE SUCCUM \$  
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials (I certify that the signature on this document applies to the bill and on which a bill is sent)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# ( )

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

PCIA

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX

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

5. PATIENT'S ADDRESS (No. Street)

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. IS PRESENT CONDITION RELATED TO:

10. EMPLOYMENT (Current or Former)

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

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 CODE AND NUMBER (WORKER'S COMPENSATION OCCUPATIONAL ACCIDENT)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE CLAIM # CHANGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to ICD-9-CM code book)

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. ICD-9-CM H. NONCOVERING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN PIN

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT? YES NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. REVENUE NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR OFFICE (If bills to the insurer or to the insurer apply to the bill 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



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

1. MEDICARE <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No. Street)	8. INSURED'S POLICY GROUP OR POLICY NUMBER
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PRESENT CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. INSURED'S DATE OF BIRTH MM DD YY	12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	14. DATE OF CURRENT ILLNESS, INJURY, OR PRESENTLY EXISTING CONDITION	15. OTHER DATE QUAL: MM DD YY	16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)	19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	20. PHYSICIAN OR SUPPLIER INFORMATION
21. A. DATE OF SERVICE FROM TO	21. B. PLACE OF SERVICE	21. C. PROCEDURE, SERVICE, OR SUPPLIER	21. D. PHYSICIAN OR SUPPLIER
25. FEDERAL TAX ID NUMBER	26. PATIENT'S ACCOUNT NO.	27. ACCOUNT ASSIGNMENT?	28. TOTAL CHARGE
29. SIGNATURE OF PHYSICIAN OR SUPPLIER	30. SERVICE FACILITY LOCATION INFORMATION	31. BILLING PROVIDER INFO & PAY ( )	32. BILLING PROVIDER INFO & PAY ( )

# 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

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

**PHYSICIAN OR SUPPLIER INFORMATION**

25 FEDERAL TAX ID NUMBER    26 PATIENT'S ACCOUNT NO    27 ACCRUE ASSIGNMENT? (If "NO," check "Other" in 27)    28 TOTAL CHARGE \$    29 AMOUNT PAID \$    30 REVENUE MISC USE \$

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If entry in 31 or 32 is required, this entry applies to the 31 and not vice versa.)    32 SERVICE FACILITY LOCATION INFORMATION    33 BILLING PROVIDER INFO & Pfx# ( )

**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 (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, M, F, 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 (YES, NO) 11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits other than cash to be paid to the party 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 PREVIOUSLY CLAIMED (MM, DD, YY) 15. OTHER DATE (MM, DD, YY) 16. DATE OF BIRTH (MM, DD, YY) WORK-RELATED OCCUPATION (JOB, TITLE, TO, FROM, YEAR)

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE** 17a. NPI 17b. NPI

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) 19. PRESCRIPTION (DRUG, ORIGINAL REF. NO.) 20. PRIOR AUTHORIZATION NUMBER

21. A. DATE(S) OF SERVICE (From, To, MM, DD, YY) B. PLACE OF SERVICE (ICD-9-CM) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. RATE PER UNIT G. UNIT QUANTITY H. PROVIDING PHYSICIAN'S #

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 (INCLUDES ADDRESS OF CARE CENTER) 29. SERVICE FACILITY LOCATION INFORMATION 30. BILLING PROVIDER INFO & PAY ( )

# Line Items 17 and 17b

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

# EMC Equivalent Lines 17 and 17b

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
17	Name of Referring physician or other source	2310A	NM103 (DN)	Referring provider last name	Required if claim involved a referral or services were ordered. When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (2310A) loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separate claim must be billed for each ordering/referring physician.
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
		2420F**	NM103 (DN)	Referring provider last name	
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
	Name of Ordering physician	2420E	NM103 (DK)	Ordering provider last name	
			NM104	Ordering provider first name	
			NM105	Ordering provider middle name	
17a	Other ID number of Referring physician				
17b	NPI	2310A	REF02 (1C)	Referring provider primary ID	Enter "XX" in the NM108 to indicate an NPI is present in the NM109. Enter the NPI of the referring/ordering physician listed in Item 17
			REF02 (1C)		
			REF02 (1C)	Ordering provider primary ID	



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

PCIA

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

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits other than cash to be paid to the party 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 PREVIOUSLY CLAIMED 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 FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please use ICD-9-CM code) 21. HOSPITALIZATION CODE ORIGINAL REF NO.

22. PRIOR AUTHORIZATION NUMBER

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

24. FEDERAL TAX ID NUMBER 25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office unless it differs from the address on the reverse apply to the SE and on a separate part thereof.) 26. SERVICE FACILITY LOCATION INFORMATION 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. NUMBER NUCC USE

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 SELF OR 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 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 (Area Code) OFF CITY STATE ZIP CODE TELEPHONE (Area Code)

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

11. INSURED'S DATE OF BIRTH MM DD YY SEX 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 Social Security to the party who accepts assigned claim.) 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 14, 15, and 16.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Last) MM DD YY QUAL 15. CERTAIN DATE MM DD YY 16. DATE OF LAST WORK IN CURRENT OCCUPATION FROM TO

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. CHARGES YES NO 22. PRIOR AUTHORIZATION NUMBER

23. PROVIDING PROVIDER ID #

24. A. CATEGORIES OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY D. DIAGNOSIS E. CHARGES F. DATE OF SERVICE G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. FEE/SERVICES NOT COVERED

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (I certify that this statement of services applies to the bill and on which a bill is being rendered)) 32. SERVICE FACILITY LOCATION INFORMATION 33. 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

PCIA  PICA

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY  STATE

5. ZIP CODE  TELEPHONE (provide Area Code)

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

7. OTHER INSURED'S POLICY OR GROUP NUMBER

8. EMPLOYMENT (Current or Former)  YES  NO

9. AUTO ACCIDENT?  YES  NO

10. OTHER ACCIDENT?  YES  NO

11. IS THIS CLAIM RELATED TO A PREVIOUS CLAIM?  YES  NO

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

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

14. NAME OF REFERRING PROVIDER OR OTHER SOURCE

15. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

20. OUTSIDE LAB?  YES  NO  \$ CHARGES

21. FEDERAL TAX ID NUMBER

22. PATIENT'S ACCOUNT NO.

23. TOTAL CHARGE

24. SIGNATURE OF PHYSICIAN OR SUPPLIER

25. SERVICE FACILITY LOCATION INFORMATION

26. BILLING PROVIDER INFO & P#

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER/NOV (LIFE) 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	
6. PATIENT RELATIONSHIP TO INSURED		9. ZIP CODE TELEPHONE (Area Code)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PRESENT CONDITION RELATED TO:	
9. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR POLICY NUMBER	
10. IS PRESENT CONDITION RELATED TO:		12. INSURED'S DATE OF BIRTH MM DD YY SEX	
11. RESERVED FOR NUCC USE		13. OTHER CLAIM (Designated by NUCC)	
12. RESERVED FOR NUCC USE		14. INSURANCE PLAN NAME OR PROGRAM NAME	
13. RESERVED FOR NUCC USE		15. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
14. INSURANCE PLAN NAME OR PROGRAM NAME		16. IS THIS ANOTHER HEALTH BENEFIT PLAN?	
15. 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 provision of benefits other than cash to the party who accepts assignment below.)		17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)	
16. STATE OF CURRENT RESIDENCE, INJURY, IF PREVIOUSLY CLAIMED		18. OTHER DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))		21. HIRSHBERG CODE ORIGINAL REF NO.	
A. _____ B. _____ C. _____ D. _____		22. PRIOR AUTHORIZATION NUMBER	
E. _____ F. _____ G. _____ H. _____			
I. _____ J. _____ K. _____ L. _____			
25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.	
26. PATIENT'S ACCOUNT NO.		27. ACCOUNT ASSIGNMENT?	
27. ACCOUNT ASSIGNMENT?		28. TOTAL CHARGE	
28. TOTAL CHARGE		29. AMOUNT PAID	
29. AMOUNT PAID		30. RESUBMIT NUCC USE	
30. RESUBMIT NUCC USE			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address of credentials office that the claimant or the insurer apply to the SE and set it with a post office)		32. SERVICE FACILITY LOCATION INFORMATION	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PAY ( )	
33. BILLING PROVIDER INFO & PAY ( )			

## Line Item 21

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



# EMC Equivalent Line 21

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



# Line Item 22

- Not required
- Not mapped electronically

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

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

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

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

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

5. PATIENT'S RELATIONSHIP TO INSURED

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

7. IS THIS PATIENT'S CONDITION RELATED TO:

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS THIS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

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

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

15. OTHER DATE (MM/DD/YY)

16. DATE OF 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. OFFICE LAMP

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 (MM/DD/YY)  B. PLACE OF SERVICE (ICD-9-CM)  C. PROVIDER, SUPPLIER, OR SUPPLY (ICD-9-CM)  D. DIAGNOSIS (ICD-9-CM)  E. CHARGE

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

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials. I certify that this statement of services applies to the bill and on which a part benefit.)

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PRF

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN OTHER 1% INSURED'S ID NUMBER (For Programs 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 NUCC USE CITY STATE

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

4. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT (Current or Former) 6. INSURED'S DATE OF BIRTH SEX

5. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) 8. OTHER CLAIMS (Pre-qualified by NUCC)

c. OTHER ACCIDENT? 9. INSURANCE PLAN NAME OR PROGRAM NAME

4. INSURANCE PLAN NAME OR PROGRAM NAME 10c. CLAIM CODES (Designated by NUCC) 12. 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 payment 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 authorized physician or supplier for services described below.

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

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

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

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. DATES OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. PROVIDER IDENTIFICATION E. CHARGES F. UNIT G. RATE H. PRODUCT IDENTIFICATION #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CONTACTS (If bills for the claim are to be rendered apply to the SE and send with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ( )

# Line Item 23

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

# EMC Equivalent Line 23

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



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR OTHER OTHER  
 Medicare  Medicaid  Tricare  CHIP/VA  Group Health Plan  Self or 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) 6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other) 7. INSURED'S ADDRESS (No. Street)

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

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO: a. EMPLOYMENT (Current or Former) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 10. INSURED'S POLICY GROUP OR POLICY NUMBER 11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 12. OTHER CLAIM# (Designated by NUGO) 13. INSURANCE PLAN NAME OR PROGRAM NAME 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) 15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits other than cash to be paid to the party who accepts assigned claim.) 16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described herein.)

17. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM/DD/YY) 18. OTHER DATE (QUAL, MM/DD/YY) 19. OTHER DATE (MM/DD/YY) 20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) 21. OUTSIDE LAB? (Yes/No) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 12 months) (A, B, C, D, E, F, G, H)

# 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 POINTER	CHARGE/FEES	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 2002

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)

8. CITY STATE 9. RESERVED FOR NUCC USE 10. CITY STATE

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE 16. 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 CLAIM # CHANGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) 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 (Designation: Outpatient, Outpatient, Outpatient, Outpatient) D. PHYSICIAN CODE E. CHANGES F. DATE OF SERVICE G. ID. QUAL. H. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID. NUMBER SSN EIN

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

31. BILLING PROVIDER INFO & PAY ( )

# Line Item 25

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

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

# Line Item 26

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

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

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

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

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

3. PATIENT'S ADDRESS (No. Street)   
 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. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. EMPLOYMENT (Current or Previous)  YES  NO

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

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 LAST WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAMP  YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. HIRE NUMBER CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE  B. PLACE OF SERVICE  C. PROCEDURE, SERVICE, OR SUPPLY  D. DIAGNOSIS

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?  YES  NO

28. TOTAL CHARGE

29. BILLING PROVIDER INFO



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 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) 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 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 authorized physician or supplier for services described below.

14. DATE OF CURRENT CLAIM (Month, Day, Year) 15. OTHER DATE (Month, Day, Year) 16. DATE OF BIRTH (Month, Day, Year) WORK IN CURRENT OCCUPATION (Month, Day, Year)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (From, To)

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 20. OUTSIDE LAB? (Yes/No) \$ CHARGES

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

24. A. CARRIER OF SERVICE	B. PLACE OF SERVICE	C. PROCEDURE, SERVICE, OR SUPPLY	D. DIAGNOSIS	E. CHARGES	F. TOTAL CHARGE	G. AMOUNT PAID	H. RESERVE MUCC USE
From (MM, DD, YY)	To (MM, DD, YY)	ICD-9-CM	ICD-9-CM	\$ CHARGES	\$ CHARGES	\$ CHARGES	
1							
2							
3							
4							
5							
6							

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office) 32. SERVICE FACILITY LOCATION (City, State, Zip) 33. BILLING PROVIDER INFO (Name, Address, City, State, Zip)

# 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	QU07	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 IS OR WAS COVERED UNDER OTHER HEALTH PLAN

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

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

7. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

8. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

9. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

10. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

11. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

12. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

13. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

14. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

15. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

16. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

17. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

18. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

19. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

20. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

21. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

22. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

23. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

24. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

25. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

26. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

27. IS THIS CLAIM RELATED TO ANOTHER CLAIM? YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if any that the claimer or his or her agent apply to the bill and on which a bill is based)

32. SERVICE FACILITY LOCATION INFORMATION

33. 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 NON-EMPLOYEE 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 (Include Area Code)

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

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. 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 AND NUMBER OF WORK-RELATED OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. OUTSIDE LABOR CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER D. DIAGNOSIS E. CHARGES F. ICD-9-CM G. ICD-9-CM H. PROVIDING AGENCY I. #

25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. NUMBER NUGO USE

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PAY ( )

# Line Item 31

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

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

# Line Item 32

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

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

## HEALTH INSURANCE CLAIM FORM

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

PCIA

1. MEDICARE  MEDICAID  TRICARE  CHIP/ERA  GROUP HEALTH PLAN  POLY PLAN  OTHER

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

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

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

5. PATIENT'S RELATIONSHIP TO INSURED

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

7. IS PHYSICIAN'S CONDITION RELATED TO EMPLOYMENT?

8. INSURED'S POLICY OR GROUP OR POLY NUMBER

9. INSURED'S DATE OF BIRTH

10. OTHER CLAIMED OR PAID BY MUCC

11. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENTS OR AUTHORIZED PERSONS SIGNATURE

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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 REPORTING PROVIDER OR OTHER SOURCE

18. NPI (10/17)

19. ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. HPSA MARKING CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) B. PLACE OF SERVICE (FACILITY) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. NPI G. BILLING PROVIDER ID #

25. FEDERAL TAX ID NUMBER (SSAN) SER. SN.

26. SIGNATURE OF PHYSICIAN OR SUPPLIER

27. SERVICE FACILITY LOCATION INFORMATION

28. TOTAL CHARGE (A) 29. AMOUNT PAID (B) 30. REMAINING MUCC USE (C)

31. BILLING PROVIDER INFO & PRF ( )

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR COV (LEAF) OTHER  
 Medicare  Medicaid  Tricare  CHIP/VA  Group Health Plan  Self or COV (Leaf)  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 MS) 7. INSURED'S ADDRESS (No. Street)

8. CITY STATE 9. RESERVED FOR MUCC USE 10. CITY STATE

11. INSURED'S POLICY GROUP OR FICA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits other to myself or to the party who accepts assigned claim.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 20. OUTSIDE LABORATORY (YES NO) \$ CHARGE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 60 days) (ICD-9-CM) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (From To) B. PLACE OF SERVICE (CPT/HCPCS) C. PROCEDURE, SERVICE, OR SUPPLIER (CPT/HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGE \$ CHARGE F. ORDERING PROVIDER ID #

25. FEDERAL TAX ID NUMBER (SSN) 26. TOTAL CHARGE 27. AMOUNT PAID 28. RESERVED FOR MUCC USE

29. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDE ADDRESS OR CARE OFFICE) (CERTIFY THAT THE CLAIM IS TO BE PAID TO THE SET AND NOT TO A PART SERVICE)

30. BILLING PROVIDER INFO & PAY ( )

31. SERVICE FACILITY LOCATION INFORMATION (A. B.)

# 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.
		2400**	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 FQA number	

# Line Items 33 and 33a

- Required on all claims
  - Provider's billing name, telephone number, 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
			N401	Provider city	
33a	NPI	2010AA	PER04	Provider state	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.
			PER03	Provider ZIP code	
			PER04	Provider phone number	
			NM109 (85)	Provider ID	
33b	Billing Taxonomy Number	2005A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PKC

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

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

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

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

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 21. PRELIMINARY CODES (ORIGINAL PIP NO.) 22. PRIOR AUTHORIZATION NUMBER

23. FEDERAL TAX ID NUMBER 24. PATIENT'S ACCOUNT NO. 25. ACCOUNT ASSIGNMENT? 26. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on this invoice apply to this bill and are a part thereof.) 27. SERVICE FACILITY LOCATION INFORMATION 28. BILLING PROVIDER INFO & PH 1

# 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 <b>insured's</b> 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](#)

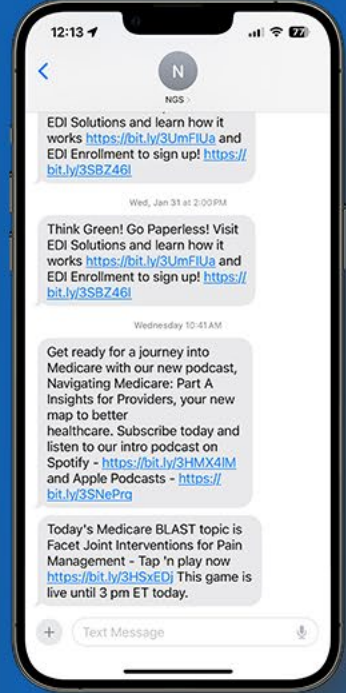
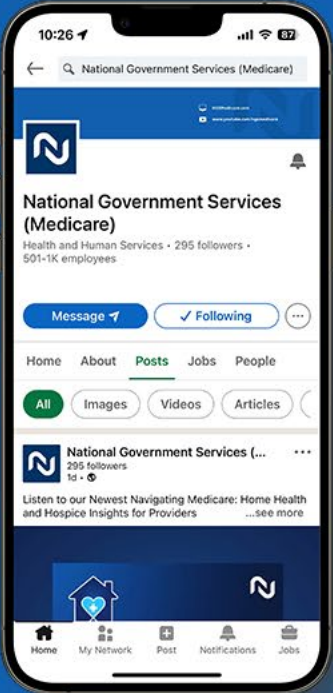



# Resources, References and Tools


# 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](#)

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# Questions?

Thank you!