

Proper Part B Claim Submissions

10/31/2024

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
Education Consultants

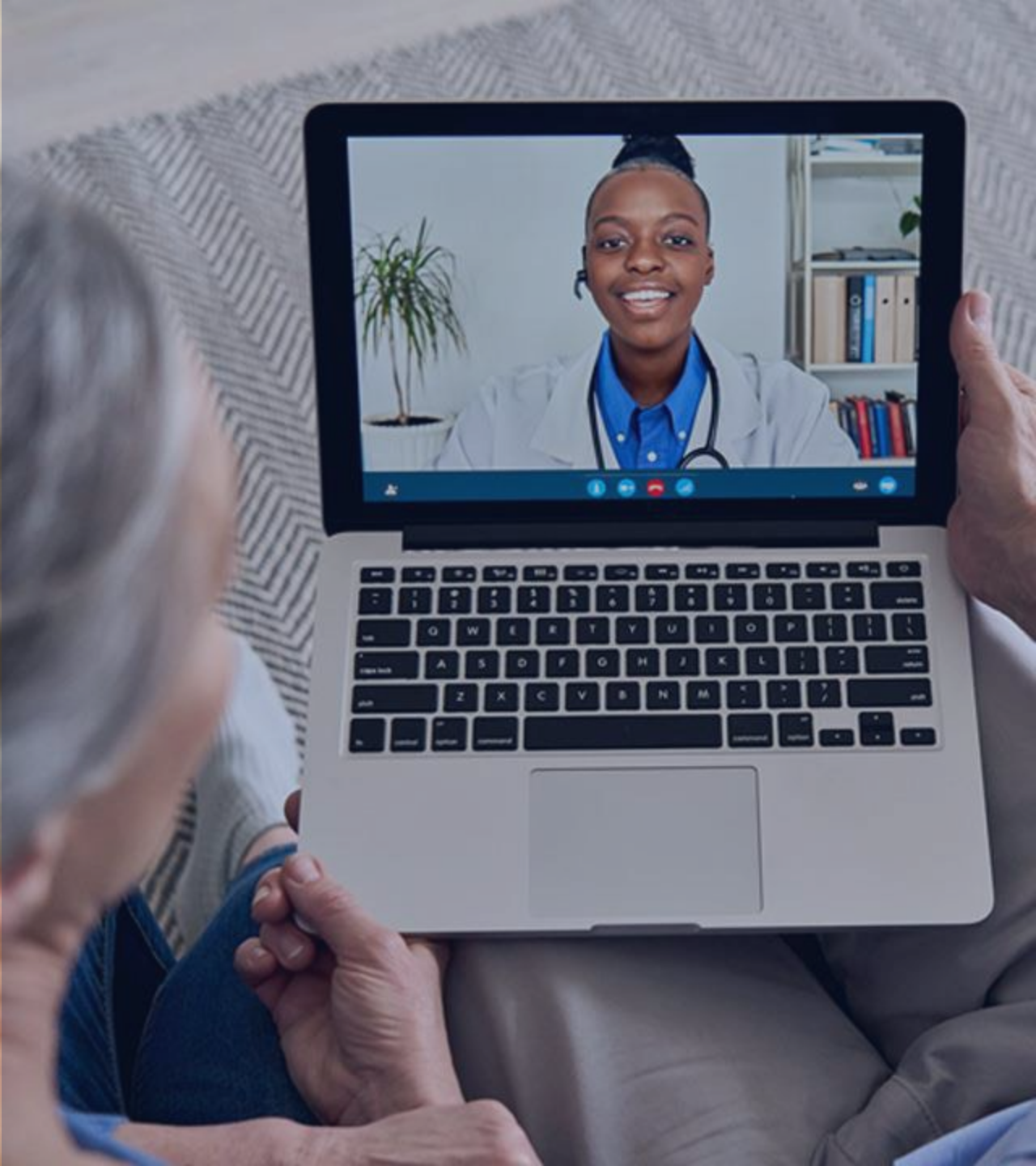
- Arlene Dunphy, CPC
- Carleen Parker





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Objective

After completion attendees will be able to

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



Agenda

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

Claim Form Requirements

Claim Submission Requirements

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



ASCA Regulations

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

Time Limits for Filing Medicare Claims

Claim Filing Time Limits

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



Claim Form Overview

CMS-1500 Claim Form (02/12)

Beneficiary data

Provider data

HEALTH INSURANCE CLAIM FORM
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

SECTION 1: PATIENT INFORMATION
1. PATIENT'S NAME (LAST, FIRST, MIDDLE)
2. PATIENT'S DATE OF BIRTH (MM/DD/YYYY)
3. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP)
4. PATIENT'S PHONE NUMBER (AREA CODE, NUMBER)
5. PATIENT'S SOCIAL SECURITY NUMBER (SSN)
6. PATIENT'S EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)
7. PATIENT'S OCCUPATION (NAME, ADDRESS, CITY, STATE, ZIP)
8. PATIENT'S MARITAL STATUS (MARRIED, SINGLE, DIVORCED, WIDOWED)
9. PATIENT'S RELIGION (NAME, ADDRESS, CITY, STATE, ZIP)
10. PATIENT'S RACE (WHITE, BLACK, HISPANIC, ASIAN, OTHER)
11. PATIENT'S SEX (MALE, FEMALE)
12. PATIENT'S ETHNICITY (HISPANIC, ASIAN, OTHER)
13. PATIENT'S CURRENT HEALTH STATUS (WELL, CHRONIC, ACUTE, OTHER)
14. PATIENT'S CURRENT MEDICATIONS (NAME, DOSE, FREQUENCY, INDICATION)
15. PATIENT'S CURRENT PHYSICIAN (NAME, ADDRESS, CITY, STATE, ZIP)
16. PATIENT'S CURRENT SPECIALIST (NAME, ADDRESS, CITY, STATE, ZIP)
17. PATIENT'S CURRENT HOSPITAL (NAME, ADDRESS, CITY, STATE, ZIP)
18. PATIENT'S CURRENT INSURANCE (NAME, ADDRESS, CITY, STATE, ZIP)
19. PATIENT'S CURRENT POLICY NUMBER (NAME, ADDRESS, CITY, STATE, ZIP)
20. PATIENT'S CURRENT GROUP NUMBER (NAME, ADDRESS, CITY, STATE, ZIP)
21. PATIENT'S CURRENT CLASSIFICATION (NAME, ADDRESS, CITY, STATE, ZIP)
22. PATIENT'S CURRENT PLAN (NAME, ADDRESS, CITY, STATE, ZIP)
23. PATIENT'S CURRENT COVERAGE (NAME, ADDRESS, CITY, STATE, ZIP)
24. PATIENT'S CURRENT BENEFIT (NAME, ADDRESS, CITY, STATE, ZIP)
25. PATIENT'S CURRENT PREMIUM (NAME, ADDRESS, CITY, STATE, ZIP)
26. PATIENT'S CURRENT DEDUCTIBLE (NAME, ADDRESS, CITY, STATE, ZIP)
27. PATIENT'S CURRENT COINSURANCE (NAME, ADDRESS, CITY, STATE, ZIP)
28. PATIENT'S CURRENT OUT-OF-POCKET (NAME, ADDRESS, CITY, STATE, ZIP)
29. PATIENT'S CURRENT MAXIMUM BENEFIT (NAME, ADDRESS, CITY, STATE, ZIP)
30. PATIENT'S CURRENT ELIGIBILITY (NAME, ADDRESS, CITY, STATE, ZIP)

SECTION 2: PROVIDER INFORMATION
31. PROVIDER'S NAME (LAST, FIRST, MIDDLE)
32. PROVIDER'S DATE OF BIRTH (MM/DD/YYYY)
33. PROVIDER'S ADDRESS (STREET, CITY, STATE, ZIP)
34. PROVIDER'S PHONE NUMBER (AREA CODE, NUMBER)
35. PROVIDER'S SOCIAL SECURITY NUMBER (SSN)
36. PROVIDER'S EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)
37. PROVIDER'S OCCUPATION (NAME, ADDRESS, CITY, STATE, ZIP)
38. PROVIDER'S MARITAL STATUS (MARRIED, SINGLE, DIVORCED, WIDOWED)
39. PROVIDER'S RELIGION (NAME, ADDRESS, CITY, STATE, ZIP)
40. PROVIDER'S RACE (WHITE, BLACK, HISPANIC, ASIAN, OTHER)
41. PROVIDER'S SEX (MALE, FEMALE)
42. PROVIDER'S ETHNICITY (HISPANIC, ASIAN, OTHER)
43. PROVIDER'S CURRENT HEALTH STATUS (WELL, CHRONIC, ACUTE, OTHER)
44. PROVIDER'S CURRENT MEDICATIONS (NAME, DOSE, FREQUENCY, INDICATION)
45. PROVIDER'S CURRENT PHYSICIAN (NAME, ADDRESS, CITY, STATE, ZIP)
46. PROVIDER'S CURRENT SPECIALIST (NAME, ADDRESS, CITY, STATE, ZIP)
47. PROVIDER'S CURRENT HOSPITAL (NAME, ADDRESS, CITY, STATE, ZIP)
48. PROVIDER'S CURRENT INSURANCE (NAME, ADDRESS, CITY, STATE, ZIP)
49. PROVIDER'S CURRENT POLICY NUMBER (NAME, ADDRESS, CITY, STATE, ZIP)
50. PROVIDER'S CURRENT GROUP NUMBER (NAME, ADDRESS, CITY, STATE, ZIP)
51. PROVIDER'S CURRENT CLASSIFICATION (NAME, ADDRESS, CITY, STATE, ZIP)
52. PROVIDER'S CURRENT PLAN (NAME, ADDRESS, CITY, STATE, ZIP)
53. PROVIDER'S CURRENT COVERAGE (NAME, ADDRESS, CITY, STATE, ZIP)
54. PROVIDER'S CURRENT BENEFIT (NAME, ADDRESS, CITY, STATE, ZIP)
55. PROVIDER'S CURRENT PREMIUM (NAME, ADDRESS, CITY, STATE, ZIP)
56. PROVIDER'S CURRENT DEDUCTIBLE (NAME, ADDRESS, CITY, STATE, ZIP)
57. PROVIDER'S CURRENT COINSURANCE (NAME, ADDRESS, CITY, STATE, ZIP)
58. PROVIDER'S CURRENT OUT-OF-POCKET (NAME, ADDRESS, CITY, STATE, ZIP)
59. PROVIDER'S CURRENT MAXIMUM BENEFIT (NAME, ADDRESS, CITY, STATE, ZIP)
60. PROVIDER'S CURRENT ELIGIBILITY (NAME, ADDRESS, CITY, STATE, ZIP)



NUCC Approved OMB

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

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

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (TRICARE ID#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (GHP) FECA (FECA LINE#) OTHER (Other ID#)

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

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

8. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) (YES NO) 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 report or to the party who accepts assignment below.) SIGNED DATE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB \$ CHARGES (YES NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-I to service the below (PHE) (ICD list) A. I. B. J. C. K. D. L. E. F. G. H. I. J. K. L. 22. REGISTRATION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICES (From MM DD YY To MM DD YY) B. PLACE OF SERVICE (C) PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) (CPT/HCPCS) D. DIAGNOSIS POINTER E. DAYS OF 100% F. \$ CHARGES G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT (For gov. claims, see back) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING (SE-ORIGIN OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and were made a part thereof.) SIGNED DATE 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PIN# ()

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

HEALTH INSURANCE CLAIM FORM

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

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

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

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

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

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

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 11. INSURED'S POLICY GROUP OR FECA NUMBER

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

14. DATE OF CURRENT SURGERY, INJURY, OR PROSPECTED SURG. 15. OTHER DATE 16. DATE PATIENT BECAME ELIGIBLE TO WORK IN CURRENT OCCUPATION

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

19. ADDITIONAL CLAIM INFORMATION 20. OUTPATIENT CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 22. ICD-9-CM CODES

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE B. PLACE OF SERVICE C. PROVIDER, SUPPLIER OR SUPPLIER D. DIAGNOSIS E. CHARGES F. CHARGE PERCENTAGE G. REFERRING PHYSICIAN ID #

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

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

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 PATIENT'S CONDITION RELATED TO OTHER ACCIDENT? YES NO 11. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts assignment below.)

14. DATE OF CURRENT SURGICAL INJURY, OR PROSPECTIVE CARE (MM DD YY) 15. CLAIM DATE (MM DD YY)

16. DATE (MM DD YY) WHEN OCCURRENCE OCCURRED (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SN 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 REP. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (From To) B. PLACE OF SERVICE (EMG) C. PROGRAMME, PHYSICIAN OR SUPPLIER (English, Spanish, Quechua, Aymara, Other) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. ICD-9-CM G. ICD-9-CM H. ICD-9-CM I. PROVIDING PROVIDER ID #

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

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

10. INSURED'S POLICY OR GROUP NUMBER

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 SERVICE

15. OTHER DATE

16. DATE OF SERVICE

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB

21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY

22. HEMORRHOID CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER OR SUPPLIER (Origin, Unk, or Other) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. ICD-9-CM G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NN. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VV. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. REMARKS/NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

Line Item 2

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

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

Line Item 3

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

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

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

PCIA PICA

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

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

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

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

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

14. DATE OF CLAIMED SURVIVAL, INJURY, OR PREGNANCY (MM DD YY) QUAL. 15. OTHER DATE (MM DD YY) QUAL. 16. DATE OF CLAIM (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? (YES NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Name, AC, External, ICD-9-CM) 22. PRESCRIPTION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (From To) B. PLACE OF SERVICE (Place of Service) C. PROCEDURE, SUPPLY, OR SUPPLIER (ICD-9-CM, HCPCS, NDC, Brand) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. PAYMENT (ICD-9-CM) G. CLAIM ID. H. PROVIDER WORKER ID #

25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE (A) 29. AMOUNT PAID (B) 30. INVOICED BY (C) 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials to certify that the statement on this invoice applies to the bill and can be a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAF# ()

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

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

3. PATIENT'S BIRTH DATE

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

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

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

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

11. INSURED'S POLICY GROUP OR POLA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

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

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LABOR CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO PLACE OF SERVICE B. PROCEDURE, SERVICE, OR SUPPLIER C. DIAGNOSIS D. CHARGES E. CHARGES F. RATE G. RATE H. RATE I. RATE J. RATE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. REVIEW NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

Line Item 4

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

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

Line Item 5

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

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

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

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

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

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

6. OTHER INSURER'S POLICY OR GROUP NUMBER 7. EMPLOYMENT (Current or Pending) YES NO 8. AUTO ACCIDENT? YES NO PLACE (State) 9. OTHER CLAIM? (One paid by NUCC) YES NO 10. INSURANCE PLAN NAME OR PROGRAM NAME 11. INSURER'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 to be paid to the party who accepts assignment.) 13. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLASS (MM/DD/YY) QUAL. 15. OTHER DATE (MM/DD/YY) QUAL. 16. DATE PATIENT CAME TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN IFA IFA) 18. HOUR TO START DATE RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO 21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Nucleic Acid, Enzyme, or Other) (ICD-9-CM) A. B. C. D. E. F. G. H. I. J. 22. ICD-9-CM CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0512

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

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

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

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

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

6. OTHER INSURED'S POLICY OR GROUP NUMBER 12. EMPLOYMENT (Current or Previous) 12. EMPLOYMENT (Current or Previous)

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

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITAL/CLINICAL DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below) 20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below)

21. A. B. C. D. E. F. G. H. I. J. K. L. 21. A. B. C. D. E. F. G. H. I. J. K. L.

22. A. CARRIER 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 #

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

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (Only if the claim is for the services apply to the 99 and are on a bill a part thereof) 30. SERVICE FACILITY LOCATION INFORMATION 31. 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) 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 Part D to the party who accepts assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE () 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM / TO) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABOR CHARGES YES NO 21. PRIOR AUTHORIZATION NUMBER

22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) () 23. PHYSICIAN CODE ORIGINAL REF. NO. 24. A. CARRIER OF SERVICE () B. PLACE OF SERVICE () C. PROCEDURE, SERVICE, OR SUPPLY () D. DIAGNOSIS () E. CHARGES () F. AMOUNT PAID () G. NUMBER OF SERVICES () H. PROVIDER INFORMATION ()

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 POLY (LEAF) OTHER		14. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED		9. INSURED'S POLICY GROUP OR POLY NUMBER	
10. EMPLOYMENT (Current or Former)		11. INSURED'S DATE OF BIRTH MM DD YY SEX	
12. AUTO ACCIDENT? PLACE (State)		13. OTHER CLAIM? (Designated by NUCC)	
14. OTHER ACCIDENT? PLACE (State)		15. INSURANCE PLAN NAME OR PROGRAM NAME	
16. CLAIM CODES (Designated by NUCC)		17. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
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 payment credits other to myself or to the party who accepts assigned claim.		19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described herein.	
20. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED		21. DATE OF WORK IN CURRENT OCCUPATION	
22. NAME OF REFERRING PROVIDER OR OTHER SOURCE		23. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		25. OUTSIDE LABOR CHARGES	
26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		27. PHYSICIAN ORDER ORIGINAL REF. NO.	
28. PRIOR AUTHORIZATION NUMBER		29. PHYSICIAN OR SUPPLIER INFORMATION	
30. FEDERAL TAX ID NUMBER		31. PATIENT'S ACCOUNT NO.	
32. SIGNATURE OF PHYSICIAN OR SUPPLIER		33. SERVICE FACILITY LOCATION INFORMATION	
34. TOTAL CHARGE		35. 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) 0812

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 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 (Include Area Code)
 6. PATIENT RELATIONSHIP TO INSURED (MR, MRS, MS, MISS, CHILD, OTHER)
 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)
 8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT (Current or Previous) YES NO
 b. AUTO ACCIDENT? PLACE (State) YES NO
 c. OTHER ACCIDENT? YES NO
 11. INSURED'S POLICY OR GROUP OR FEDCA NUMBER
 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)
 13. OTHER CLAIM ID (Designated by NUCC)
 14. INSURANCE PLAN NAME OR PROGRAM NAME
 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete below, No, No No)

16. SIGNATURE OF AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits other than a) to myself or to the party whose name is assigned below.)
 SIGNED: _____ DATE: _____

17. DATE OF CURRENT SURGICAL INJURY, IF PREVIOUSLY CLAIMED (MM/DD/YY) QUAL (QUAL) 18. CLAIM DATE (MM/DD/YY)
 19. NAME OF REFERRING PROVIDER OR OTHER SOURCE (NAME, ADDRESS, PHONE) 20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO)
 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 22. OUTSIDE CLAIM # (CHARGE)
 23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events/conditions) (ICD-9-CM) 24. PRIOR AUTHORIZATION NUMBER
 A. _____ B. _____ C. _____ D. _____
 E. _____ F. _____ G. _____ H. _____
 I. _____ J. _____ K. _____ L. _____

24. A. DATE OF SERVICE	B. PLACE OF SERVICE	C. PROCEDURE, SERVICE, OR SUPPLIER	D. DIAGNOSIS	E. CHARGE	F. CHARGE	G. DATE OF SERVICE	H. PLACE OF SERVICE	I. PROCEDURE, SERVICE, OR SUPPLIER	J. DIAGNOSIS	K. CHARGE	L. CHARGE
1											
2											
3											
4											
5											
6											

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the diagnosis or procedure codes apply to the ICD-9-CM and ICD-9-CM-PCS codes)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY # ()

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 (LNU) OTHER 1a INSURED'S ID NUMBER (for Program in Sect 1)

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

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

5. PATIENT'S ADDRESS (incl. Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (incl. Street)

8. RESERVED FOR FUTURE USE OFF STATE

9. OTHER INSURED'S NAME, Last Name, First Name, Middle Initial 10. IS PATIENT'S CONDITION RELATED TO:

11. RESERVED FOR FUTURE USE OFF STATE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S POLICY GROUP OR POLICY NUMBER

14. DATE OF CLAIM SUBJECT TO POLICY OR PROGRAM GROUP 15. OTHER DATE MM DD YY

16. DATE OF SERVICE 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. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL ICD-9-CM codes below ICD-9-CM) 22. HEMISPHERON CODE ORIGINAL REP. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY D. DIAGNOSIS PORTAL E. CHARGE F. DATE OF SERVICE G. 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. PAYEE'S ACCOUNT NO.

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

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 HEALTH 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'S 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 claim)

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. PHYSICIAN CODE (ORIGINAL REF. NO.)

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 signature or business reply to the SE and on main e-pat form)) 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-COVERED OTHER % INSURED'S ID NUMBER (For Programs in Item 1)

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

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

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

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

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

11b. OTHER CLAIM ID (Designated by NUCC)

11c. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

13. DATE SIGNED

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 90 days) A. B. C. D. E. F. G. H. I. J. K. L. 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Designate Unlicensed, Out-of-State, or Medicare) D. PHYSICIAN IDENTIFICATION NUMBER E. CHARGE F. ICD-9-CM G. ICD-9-CM H. ICD-9-CM I. ICD-9-CM J. ICD-9-CM K. ICD-9-CM L. ICD-9-CM

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

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

Line Items 11, 11a-11d

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

EMC Equivalent Line 11, 11a-11c

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

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

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

Line Item 12

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

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

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F)
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 6. PATIENT RELATIONSHIP TO INSURED (NEE, SPOUSE, CHILD, OTHER)
 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 9. OTHER INSURED'S POLICY OR GROUP NUMBER
 10. IS PATIENT'S CONDITION RELATED TO (YES/NO)
 11. INSURED'S POLICY GROUP OR FEDCA NUMBER
 12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)
 SIGNED _____ DATE _____
 13. EMPLOYMENT (Current or Former) (YES/NO) PLACE (State)
 14. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F)
 15. OTHER CLAIM ID (Designated by NUCC)
 16. INSURANCE PLAN NAME OR PROGRAM NAME
 17. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) If yes, complete Item 9, 10, and 11.
 18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)
 SIGNED _____

19. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Name, Address, City, State, ZIP Code, Telephone)
 20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO)
 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 22. OUTSIDE CLAIM? (YES/NO) \$ CHARGES
 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (From, To) B. PLACE OF SERVICE (PLACE OR STATE) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM, CPT, HCPCS, DRUGS, SUPPLIES) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. INPATIENT OR OUTPATIENT (I, O) G. QUAL. (1, 2, 3, 4) H. PROVIDING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE OR CREDENTIALS (I certify that the signature on this claim applies to the bill and on which a bill is sent)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PIN# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

PCIA

1. MEDICARE MEDIGAP TRICARE CHIRVA GROUP HEALTH PLAN SELF OR CO-INSURED OTHER

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

3. PATIENT'S BIRTH DATE

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Area Code)

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

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

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

15. OTHER DATE

16. OTHER CODE

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION

20. OUTSIDE CLAIM

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

Line Item 13

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

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

Line Item 14

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/00/0012

1. MEDICARE MEDICAID TRICARE CHAMPVA GEHAIP HEALTH PLAN (LIP) DELOE (LIP) OTHER

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. EMPLOYMENT (Current or Former)

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S POLICY OR GROUP OR POLICY NUMBER

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

15. HOUR/TIME/DATE(S) RELATED TO CURRENT SERVICES

16. DATE OF PATIENT'S LAST WORKING OCCUPATION (MM DD YY)

17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

19. PROCEDURE, SERVICE, OR SUPPLIER (Design Universal Organization or HCPCS)

20. PRIOR AUTHORIZATION NUMBER

21. FEDERAL TAX ID NUMBER

22. PATIENT'S ACCOUNT NO.

23. SIGNATURE OF PHYSICIAN OR SUPPLIER

24. SERVICE FACILITY LOCATION INFORMATION

25. BILLING PROVIDER INFO & P.H.#

Line Item 16

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

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

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

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

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

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

CITY STATE 8. RESIDENT FOR MEDICAL USE OFFICE STATE

ZIP CODE TELEPHONE (provide area code)

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

12. 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 credit after 90 days if I am the party who accepts assignment claim.) DATE

13. INSURED'S DATE OF BIRTH (MM/DD/YY) 14. INSURED'S POLICY OR GROUP OR PEOA NUMBER

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

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

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

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

20. OTHER CLAIM 21. PRIOR AUTHORIZATION NUMBER

22. FEDERAL TAX ID NUMBER 23. PATIENT'S ACCOUNT NO. 24. TOTAL CHARGE 25. AMOUNT PAID

26. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials (I certify that the statements on this invoice apply to this bill and are in full and fair))

27. SERVICE FACILITY LOCATION INFORMATION

28. 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 DECA/DCO OTHER 14. INSURED'S ID NUMBER (For Program in Item 1)

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

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

5. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Date) 5. OTHER CLAIMS (Other than by NUCC)

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

4. INSURANCE PLAN NAME OR PROGRAM NAME 10c. CLAIM CODES (Designated by NUCC) 6. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 14, 16, 18, 19)

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

SIGNED DATE SIGNED

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI DATES RELATED TO CURRENT SERVICES TO

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify ICD-9-CM code or other health care code) 19. PHYSICIAN CODE ORIGINAL REF. NO.

20. PRIOR AUTHORIZATION NUMBER

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

1 2 3 4 5 6

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (If bills to be claimed to or by insurance apply to the 30 and set it with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. 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	



PCIA

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

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

3. PATIENT'S BIRTH DATE 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 ZIP CODE TELEPHONE (Area Code)

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

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

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

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. HOSPITALIZATION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

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

24. FEDERAL TAX ID NUMBER SSN PIN PATIENT'S ACCOUNT NO. ACCOUNT ASSIGNMENT? TOTAL CHARGE AMOUNT PAID

25. SIGNATURE OF PHYSICIAN OR SUPPLIER SERVICE FACILITY LOCATION INFORMATION 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 (3rd and Area Code) CITY STATE ZIP CODE TELEPHONE (3rd and 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. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts assigned claim.) 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 14, 15, and 16.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Last) MM DD YY QUAL 15. OTHER 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 \$ CHARGES 21. PRIOR AUTHORIZATION NUMBER

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

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degree or credentials (Verify that the claimant or his/her agent is the one who signs a part below)) 29. SERVICE FACILITY LOCATION INFORMATION 30. BILLING PROVIDER INFO & Print ()

EMC Equivalent Line 19

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

Line Item 20

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR OTHER OTHER (For Program in Item 1)

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Provide Area Code)

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

9. PATIENT'S SEX (M F)

10. PATIENT'S RELATIONSHIP TO INSURED

11. RESIDENT FOR NUCC USE

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

13. IS PHYSICIAN'S CONDITION RELATED TO

14. EMPLOYMENT (Current or Former)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (Designated by NUCC)

18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)

19. DATE

20. SIGNED

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

22. OTHER DATE

23. NAME OF REFERRING PROVIDER OR OTHER SOURCE

24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

26. OUTSIDE LAB? YES NO

27. CHARGES

28. FEDERAL TAX ID NUMBER

29. PATIENT'S ACCOUNT NO.

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

31. SERVICE FACILITY LOCATION INFORMATION

32. 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 DECA/DCB/DCB OTHER		14. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. INSURED'S ADDRESS (No. Street)	
6. PATIENT RELATIONSHIP TO INSURED		9. INSURED'S POLICY GROUP OR POLICY NUMBER	
10. IS PRESENT CONDITION RELATED TO:		11. INSURED'S DATE OF BIRTH MM DD YY SEX	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
15. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED		16. DATE OF BIRTH AND NUMBER WORK IN CURRENT OCCUPATION	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION		20. OUTSIDE LAB	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))		22. PRIOR AUTHORIZATION NUMBER	
23. MEDICAL TAX ID NUMBER		24. PATIENT'S ACCOUNT NO.	
25. SIGNATURE OF PHYSICIAN OR SUPPLIER		26. SERVICE FACILITY LOCATION INFORMATION	

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

PCIA PIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR RETIRED 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/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 PATIENT'S CONDITION RELATED TO: 10. INSURED'S POLICY OR POLICY NUMBER

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

13. INSURANCE PLAN NAME OR PROGRAM NAME 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) (If yes, complete Item 14, 15, and 16)

15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than paid to the party who accepts assignment below.) 16. SIGNED (Print Name) DATE

17. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMED CARE (MM/DD/YY) QUAL. 18. OTHER DATE (MM/DD/YY) QUAL. 19. DATE OF CURRENT WORK-RELATED OCCUPATION (FROM/TO) (MM/DD/YY) (FROM/TO) (MM/DD/YY)

20. NAME OF REPORTING PROVIDER OR OTHER SOURCE (SSN) 21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO) (MM/DD/YY) (FROM/TO) (MM/DD/YY)

22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 23. OFFICE LAMP (Yes/No) \$ CHARGES

24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From ICD-9-CM, ICD-10-CM, or ICD-10-PCS) (ICD-9-CM) (ICD-10-CM) (ICD-10-PCS)

25. RESUBMISSION CODE ORIGINAL REF. NO.

26. A. DATES OF SERVICE (From/To) (MM/DD/YY) (MM/DD/YY) B. PLACE OF SERVICE (C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM, ICD-10-CM, or ICD-10-PCS) (D. DIAGNOSIS (ICD-9-CM, ICD-10-CM, or ICD-10-PCS) E. CHARGES (F. RATE OF SERVICE (G. UNIT OF SERVICE (H. PROVIDING PROVIDER ID #

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

33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include Degree or Credentials (Verify that the claimant or his/her agent is the MD and not a trainee or post-graduate)) 34. SERVICE FACILITY LOCATION INFORMATION 35. BILLING PROVIDER INFO & Print ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

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

Line Item 23

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

EMC Equivalent Line 23

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR OTHER OTHER
 MEDICAID 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) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 6. PATIENT'S RELATIONSHIP TO INSURED (MR/MRS/MS/MRSM/OTHER) Spouse Child Other
 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) ()
 8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO:
 10. IS PRESENT CONDITION RELATED TO:
 11. INSURED'S POLICY GROUP OR POLICY NUMBER
 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)
 13. OTHER CLAIMS (See guidelines by NUCC)
 14. INSURANCE PLAN NAME OR PROGRAM NAME
 15. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO (If yes, complete form 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100)

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/UNIT	UNITS	RENDERING/PERFORMING PHYSICIAN OR NPP
1								
2								
3								
4								
5								
6								

EMC Equivalent Lines 24A–24J

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2003

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX

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

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

6. PATIENT RELATIONSHIP TO INSURED

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

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

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

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

13. INSURANCE PLAN NAME OR PROGRAM NAME

14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete form 9, 10, 11, 12, 13)

15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized person's signature is required for payment of medical benefits to the authorized physician or supplier for services described below)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

21. OUTSIDE LABORATORY CHARGES

22. PRESCRIPTION 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 Practitioner) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. DATE OF SERVICE G. ICD-9-CM H. REFERRING PROVIDER ID #

25. FEDERAL TAX ID. NUMBER SSN EIN

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

31. BILLING PROVIDER INFO & PAY ()

Line Item 25

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

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

Line Item 26

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

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

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

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

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

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

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

5. PATIENT'S RELATIONSHIP TO INSURED Spouse Child Other

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

7. INSURED'S POLICY GROUP OR POLICY NUMBER

8. EMPLOYMENT (Current or Previous) YES NO

9. AUTO ACCIDENT? YES NO

10. OTHER CLAIM? (Designated by NUCC) YES NO

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

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 LABOR CHARGES YES NO

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

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

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

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 2005 (02)

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 MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

CITY STATE 8. RESERVED FOR MUCC USE CITY STATE

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

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment 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) 17. WORK IN CURRENT OCCUPATION (Month, Day, Year)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (Month, Day, Year)

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all events in the last 90 days) 22. PHYSICIAN CODE ORIGINAL REF NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY D. DIAGNOSIS E. CHARGES F. PAY RATE G. PAY PERIOD H. ICD-9-CM I. PROVIDING PHYSICIAN ID #

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT 27. ACCEPT ASSIGNMENT? (For PHL claims, use 2009) 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVE MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of provider) 32. SERVICE FACILITY LOCATION REFERENCE 33. BILLING PROVIDER INFO & PAY ()

Line Item 27

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	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) 0812

NUCC

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (See instructions) 16. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last name, First name, Middle Initial) 3. PATIENT'S BIRTH DATE 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 (Include Area Code) 9. ZIP CODE TELEPHONE (Include Area Code)

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

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

10. RESERVED FOR NUCC USE 14. ALSO ACCIDENT? PLACE (Date) 15. OTHER CLAIM ID (Designated by NUCC)

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

12. INSURANCE PLAN NAME OR PROGRAM NAME 18. CLAIM CODES (Designated by NUCC) 19. IS THERE ANOTHER HEALTH BENEFIT PLAN?

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits due to myself or to the party whose name is assigned below.) 14. SIGNATURE DATE 15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.) 16. SIGNATURE DATE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the below boxes) 22. REFERRAL CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Caption, License, Organization, Membership) D. DIAGNOSIS HICSDIAGNOSIS ICD-9-CM PROCEDURE CPT/HCPCS

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO

27. TOTAL CHARGE \$ 28. AMOUNT PAID \$ 29. Rsvd for NUCC Use

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if apply; the signature of the owner applies to the SE and on train a part form) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PAY #

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 (Area Code)

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

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

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

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUGO)

20. OUTSIDE LABOR CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. PHYSICIAN IDENTIFICATION E. CHARGES F. ICD-9-CM G. ICD-10 H. PROVIDING PROVIDER ID #

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

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

PCIA PCA

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

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

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Include Area Code)

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

18. OTHER INSURED'S POLICY OR GROUP NUMBER

19. IS PHYSICIAN'S CONDITION RELATED TO EMPLOYMENT? (Circle 1 or Precede)
 YES NO

20. IS AUTO ACCIDENT? (Circle 1 or Precede)
 YES NO

21. IS OTHER ACCIDENT? (Circle 1 or Precede)
 YES NO

22. IS CLAIM CODES (Designated by NUCC)

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

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

25. DATE

26. SIGNED

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

28. OTHER DATE (MM/DD/YY)

29. NAME OF REFERRING PROVIDER OR OTHER SOURCE

30. HOSPITAL DATE-ON (DATE RELATED TO CURRENT SERVICES) (MM/DD/YY)

31. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

32. OUTSIDE LAB? YES NO

33. PRIOR AUTHORIZATION NUMBER

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

35. PLACE OF SERVICE (Indicate Unusual Circumstances)

36. PROCEDURE, SERVICE, OR SUPPLIER (Designate Unusual Circumstances)

37. DIAGNOSIS (ICD-9-CM)

38. CHARGES

39. NPI

40. PROVIDING PROVIDER ID #

41. FEDERAL TAX ID NUMBER

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

43. BILLING PROVIDER INFO & Pmt#

44. TOTAL CHARGE

45. AMOUNT PAID

46. REMAINING BALANCE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

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

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

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (MR, MRS, MISS, MS, DR, OTHER) 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

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

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM DD YY) 15. OTHER DATE (MM DD YY) 16. ORDER OF SERVICE NUMBER (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 NUCC) 20. OUTSIDE LABORATORY (YES NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 60 days) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (From To) B. PLACE OF SERVICE (CPT/HCPCS) C. PROCEDURE, SERVICE, OR SUPPLIER (CPT/HCPCS) D. PHYSICIAN IDENTIFICATION NUMBER (NPI) E. CHARGE F. AMOUNT PAID G. RESERVED FOR NUCC USE

25. FEDERAL TAX ID NUMBER (SSN) 26. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDE ADDRESS OR CREDIT CARD) 27. BILLING PROVIDER INFO & PAY ()

28. 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.
		2400C**	NM109 (ZZ)		
		2400	PS101	Purchased service provider identifier	
		2420U	NM101	Identification code qualifier =00	
			NM109	Identification code	
			NM101	Identification code qualifier =0R	
			NM106	Identification code	
			NM109	Identification code	
			REF01	Reference identification qualifier =01	
		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 (NUGC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA SECA/HEALTH PLAN SECA (MILITARY) OTHER
 MEDICARE MEDICAID TRICARE CHAMPVA SECA/HEALTH PLAN SECA (MILITARY) 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 (Include Area 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. EMPLOYMENT (Current or Former) YES NO 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 DATE OF BIRTH (MM DD YY) SEX (M F) 14. INSURED'S POLICY GROUP OR PLAN NUMBER

15. OTHER CLAIM ID (Date paid by P.U.C.) 16. INSURANCE PLAN NAME OR PROGRAM NAME

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

18. DATE OF (LATEST) SURGERY, ACCIDENT, OR FRACTURE (MM DD YY) QUAL. (MM DD YY) 19. OTHER DATE (MM DD YY) 20. DATE OF SERVICE (From MM DD YY To MM DD YY) 21. PLACE OF SERVICE (EMS) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LL) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MM) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NN) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)

25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (YES/NO) 28. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on this invoice apply to this bill and are a part thereof.) 29. SERVICE FACILITY LOCATION INFORMATION 30. 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 insured's name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	

Claim Rejection Reminders

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

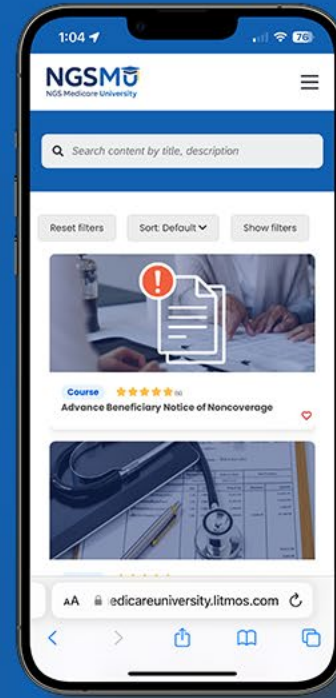
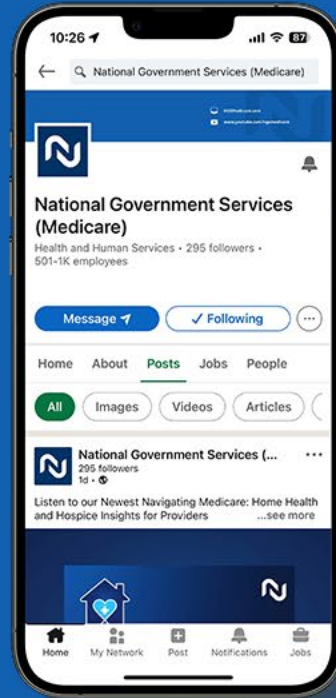
Resources, References and Tools

Resources and References

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

Questions?

Thank you!



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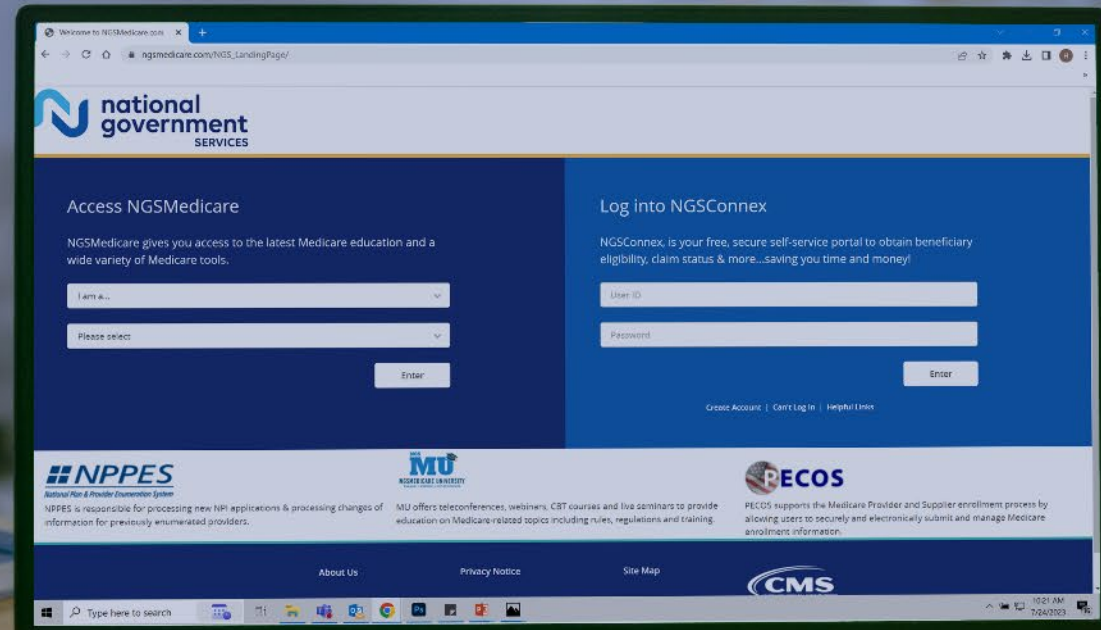


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