

Medicare Part B 2024
Spring/Summer Virtual Conference
Mastering Medicare: Tuesday Tutorials

Proper Part B Claim Submissions

6/25/2024

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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Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Objective

After completion attendees will be able to

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



Agenda

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

Claim Form Requirements

Claim Submission Requirements

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



ASCA Regulations

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

Time Limits for Filing Medicare Claims

Claim Filing Time Limits

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



Claim Form Overview

CMS-1500 Claim Form (02/12)

The diagram shows a CMS-1500 Health Insurance Claim Form with two yellow arrows pointing to specific sections. The top arrow points to the 'PATIENT AND INSURER INFORMATION' section, which includes fields for patient name, address, date of birth, sex, race, and insurance information. The bottom arrow points to the 'PROVIDER OF SERVICES INFORMATION' section, which includes fields for provider name, address, NPI, and tax identification number. A red horizontal line is drawn across the middle of the form, separating the patient information from the provider information.

Beneficiary data

Provider data



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

PATIENT AND INSURED INFORMATION

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

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO (a. EMPLOYMENT (Current or Previous) YES NO b. AUTO ACCIDENT (PLACE (Block) YES NO c. OTHER ACCIDENT YES NO) 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. RESERVED FOR NUCC USE 13. RESERVED FOR NUCC USE 14. RESERVED FOR NUCC USE 15. RESERVED FOR NUCC USE 16. RESERVED FOR NUCC USE 17. RESERVED FOR NUCC USE 18. RESERVED FOR NUCC USE 19. RESERVED FOR NUCC USE 20. RESERVED FOR NUCC USE

21. INSURANCE PLAN NAME OR PROGRAM NAME 22. RESERVED FOR LOCAL USE 23. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO If yes, complete Items 9, 10 and 11)

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (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 (DIA DTS NPI) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB \$ CHARGE (YES NO) 21. REBATE/REDEMPTION CODE ORIGINAL REF. NO.

22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include A-I, to service the below (DRE) (ICD 9-CM) A. B. C. D. E. F. G. H. I. J. K. L. 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) D. DIAGNOSIS POINTER E. CHARGE \$ F. DAYS OF 100% 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-EN 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 are 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)

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. REFERRED FOR NUCC USE
 7. REFERRED FOR NUCC USE
 8. REFERRED FOR NUCC USE

9. 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

10. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR POLICY 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 Item 9, 10, and 11)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
 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 of government benefits other than this to the party, who accepts assignment below.)
 SIGNED: _____ DATE: _____

17. DATE OF CURRENT SURVIVAL SURVIVAL OR FREQUENTLY CARE
 FROM TO QUAL
 18. LEASE DATE (MM DD YY)
 19. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SN 17S NR)
 20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO
 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 22. OUTSIDE LAB? YES NO (SCHEDULE)
 23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes) (ICD-9-CM)
 A. _____ B. _____ C. _____ D. _____
 E. _____ F. _____ G. _____ H. _____
 I. _____ J. _____ K. _____ L. _____

24. A. DATE OF SERVICE (From To) (MM DD YY MM DD YY) B. PLACE OF SERVICE (EMS) C. PROGRAMS, BENEFITS, OR SUPPLIES (English, Spanish, Quechua, Guaraní) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. CHARGE G. DATE OF SERVICE (MM DD YY) H. DATE OF SERVICE (MM DD YY) I. DATE OF SERVICE (MM DD YY) J. DATE OF SERVICE (MM DD YY) K. DATE OF SERVICE (MM DD YY) L. DATE OF SERVICE (MM DD YY)

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to the bill and not to a bill part thereof)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ()

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (See Instructions)

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

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

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

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

6. OTHER INSURED'S POLICY OR GROUP NUMBER

7. RESERVED FOR NUCC USE

8. RESERVED FOR NUCC USE

9. INSURANCE PLAN NAME OR PROGRAM NAME

10. CLAIM CODES (Designated by NUCC)

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

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

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

15. OTHER DATE (Month, Day, Year) MM DD YY

16. DATE (P) DATE (M) DATE (S) (Month, Day, Year) MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) (Last Name, First Name, Middle Initial)

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. OUTSIDE LAB? (YES/NO) \$ CHARGES

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify ALL, even those listed elsewhere) (ICD-9-CM) ORIGINAL REF. NO.

21. PRIOR AUTHORIZATION NUMBER

22. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (ICD-9-CM) C. PROVIDER, SUPPLIER, OR SUPPLIER (Design, Universal Organization) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. AMOUNT PAID (ICD-9-CM) G. NUMBER OF SERVICES (ICD-9-CM) H. PROVIDER IDENTIFICATION #

23. FEDERAL TAX ID NUMBER SSN GN PATIENT'S ACCOUNT NO. ACCOUNT ASSIGNMENT? (YES/NO) TOTAL CHARGE (ICD-9-CM) AMOUNT PAID (ICD-9-CM) NUMBER NUCC USE

24. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include all degrees or credentials) (I certify that the statements on this coverdo apply to this bill and are in accordance with a past benefit.)

25. SERVICE FACILITY LOCATION INFORMATION

26. BILLING PROVIDER INFO & PH # ()

Line Item 2

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

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

Line Item 3

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

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

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

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

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

5. PATIENT'S ADDRESS (No. Street) 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 8. EMPLOYMENT (Current or Previous) 9. INSURED'S DATE OF BIRTH MM DD YY SEX M F

10. OTHER INSURED'S POLICY OR GROUP NUMBER 11. INSURED'S POLICY GROUP OR POLICY NUMBER 12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (Authorized 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 (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

14. DATE OF CLAIMED SURVIVAL INJURY, IF PHYSICIAN (MM DD YY) QUAL. 15. OTHER DATE MM DD YY QUAL. 16. DATE OF CLAIMED SURVIVAL INJURY, IF PHYSICIAN (MM DD YY) QUAL. 17. NAME OF REPORTING PROVIDER OR OTHER SOURCE 18. HOSPITAL DATE-ON DATES RELATED TO CURRENT SERVICES FROM TO 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAMP 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Name, AC, External, ICD-9-CM, ICD-10) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SUPPLY OR SUPPLIER D. DIAGNOSIS POLYCODE E. CHARGES F. PAYOR G. REF. NO. H. ID. QUAL. I. PROVIDING PROCESSOR ID #

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

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 PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Former)

11. INSURED'S POLICY GROUP OR POLA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT SERVICE, INQUIRY, 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 LAMP

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. CHARGE E. ICD-9-CM F. PROVIDING AGENCY #

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 4

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

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

Line Item 5

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

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

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/00/0012

1. MEDICARE MEDICAID TRICARE CHRYSLER HEALTH PLAN DEERFIELD PLAN OTHER (For Program in Item 1)

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. EMPLOYER'S NAME, Last Name, First Name, Middle Initial

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

6. PATIENT'S CONDITION RELATED TO

7. EMPLOYER'S POLICY OR GROUP OR POLICY NUMBER

8. EMPLOYER'S DATE OF BIRTH

9. OTHER CLAIM ID (One paid by NUCC)

10. INSURANCE PLAN NAME OR PROGRAM NAME

11. IS THERE ANOTHER HEALTH BENEFIT PLAN?

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. PHYSICIAN'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CASE

15. OTHER DATE

16. DATE OF BIRTH

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION

19. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY

20. PHYSICIAN OR SUPPLIER IDENTIFICATION NUMBER

21. PRIOR AUTHORIZATION NUMBER

22. FEDERAL TAX ID NUMBER

23. PATIENT'S ACCOUNT NO.

24. TOTAL CHARGE

25. SIGNATURE OF PHYSICIAN OR SUPPLIER

26. SERVICE FACILITY LOCATION INFORMATION

27. BILLING PROVIDER INFO & PH#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0512

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

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

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

4. CITY STATE ZIP CODE TELEPHONE (Area Code) CITY STATE ZIP CODE TELEPHONE (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 11. EMPLOYMENT (Current or Previous) 12. INSURED'S DATE OF BIRTH SEX

7. RESERVED FOR NUCC USE 12. AUTO ACCIDENT? PLACE (State) 13. OTHER CLAIMS (Designated by NUCC)

8. RESERVED FOR NUCC USE 13. OTHER ACCIDENT? 14. INSURANCE PLAN NAME OR PROGRAM NAME

9. RESERVED FOR NUCC USE 14. CLAIM CODES (Designated by NUCC) 15. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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/allowance to be paid to the party who accepts assigned claim. 16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described below.

17. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 17. OTHER DATE 18. DATE OF BIRTH AND NUMBER TO WORK IN CURRENT OCCUPATION

19. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. HOSPITAL/CLINICAL DATES RELATED TO CURRENT SERVICES

20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAMP \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below) 21. PHYSICIAN CODE ORIGINAL REF NO.

22. A. B. C. D. E. F. G. H. I. J. K. L. 22. PRIOR AUTHORIZATION NUMBER

23. A. CARRIER OF SERVICE From To B. C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS H. CHARGES I. ICD-9-CM J. ICD-9-CM K. REFERRING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CONTACTS (Only if the claim is to be reviewed apply to the 30 and set it with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

6. PATIENT RELATIONSHIP TO INSURED
 Self Spouse Child Other

Line Item 6

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

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

Line Item 7

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

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

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

1. MEDICARE MEDICAD 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. 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 all medical or other information necessary to process this claim. I also request payment of government benefits other than just D to the party who accepts 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 LOST 15. OTHER DATE 16. DATE OF BIRTH (MM DD YY) 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. OUTSIDE LAB? YES NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (NASCAL, ICD-9-CM, ICD-10-CM) A B C D E F G H I J K L 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CPT/HCPCS PROCEDURE, SERVICE, OR SUPPLY B. DIAGNOSIS PORTION C. CHARGES D. ICD-9-CM E. ICD-10-CM F. PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (Verify that the information provided applies to this claim and use with a part below)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & Print ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

PCIA

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)

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

8. RESERVED FOR NUCC USE

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

10. OTHER INSURED'S POLICY OR GROUP NUMBER

11. RESERVED FOR NUCC USE

12. RESERVED FOR NUCC USE

13. INSURANCE PLAN NAME OR PROGRAM NAME

14. EMPLOYMENT (Current or Previous) YES NO

15. AUTO ACCIDENT? PLACE (State) YES NO

16. OTHER ACCIDENT? YES NO

17. CLAIM CODES (Designated by NUCC)

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

19. OTHER CLAIMS (Designated by NUCC)

20. INSURANCE PLAN NAME OR PROGRAM NAME

21. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 14, and 18)

22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or provision of benefits other than cash to the party who accepts assigned claim.) SIGNED DATE

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

24. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM, DD, YY) QUAL ()

25. OTHER DATE (MM, DD, YY) QUAL ()

26. DATE (AT AND UNDER) WORK-RELATED OCCUPATION (FROM, TO, MM, DD, YY)

27. NAME OF REFERRING PROVIDER OR OTHER SOURCE ()

28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO, MM, DD, YY)

29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

30. OUTSIDE LABOR CHARGES YES NO

31. PHYSICIAN CODE ORIGINAL REF. NO.

32. PRIOR AUTHORIZATION NUMBER

33. A. DATE(S) OF SERVICE (From, To, MM, DD, YY) B. PLACE OF SERVICE () C. PROCEDURE, SERVICE, OR SUPPLIER () D. DIAGNOSIS () E. CHARGES () F. ICD-9-CM () G. ICD-10 () H. PROVIDING PROVIDER ID #

1 2 3 4 5 6

34. FEDERAL TAX ID NUMBER () 35. PATIENT'S ACCOUNT NO. 36. ACCOUNT ASSIGNMENT? (YES, NO) 37. TOTAL CHARGE () 38. AMOUNT PAID () 39. NUMBER NUCC USE

40. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials if bills for the claim will be generated; apply to the bill and not to this part thereof.) 41. SERVICE FACILITY LOCATION INFORMATION 42. BILLING PROVIDER INFO & PAY ()

Line Item 8

- Reserved for future NUCC use
- Not mapped electronically

Line Items 9, 9a-9d

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

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

NUCC

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

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

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

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

6. PATIENT'S RELATIONSHIP TO INSURED
 7. IS THIS CLAIM FOR NUCC USE?

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 9. OTHER INSURED'S POLICY OR GROUP NUMBER
 10. RESERVED FOR NUCC USE
 11. RESERVED FOR NUCC USE
 12. INSURANCE PLAN NAME OR PROGRAM NAME

13. IS THIS CLAIM RELATED TO:
 14. EMPLOYMENT (Current or Former)
 15. AUTO ACCIDENT? PLACE (State)
 16. OTHER ACCIDENT?
 17. CLAIM CODES (Designated by NUCC)

18. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 19. IS INSURED OR AUTHORIZED PERSON'S SIGNATURE I and how
 20. SIGNATURE OF AUTHORIZED PERSON'S SIGNATURE I and how
 21. SIGNATURE OF AUTHORIZED PERSON'S SIGNATURE I and how

22. DATE OF CURRENT SURVIVAL SURVEY, IF PREVIOUSLY DONE
 23. CLAIM DATE
 24. DATE (MM DD YY) WHEN IN CURRENT OCCUPATION

25. NAME OF REFERRING PROVIDER OR OTHER SOURCE
 26. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
 27. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 28. OUTPATIENT
 29. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes)
 30. HEMORRHOID CODE ORIGINAL REF NO
 31. PRIOR AUTHORIZATION NUMBER

32. A. DATE OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SUPPLIER, OR SUPPLIER D. DIAGNOSIS E. CHARGE F. ICD-9-CM G. PROVIDING H. PROVIDING

33. FEDERAL TAX ID NUMBER 34. PATIENT'S ACCOUNT NO 35. ACCOUNT ASSIGNMENT? 36. TOTAL CHARGE 37. AMOUNT PAID 38. RESUBMIT NUCC USE

39. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If entity that the signature or the charge apply to the SE and on trade a part thereof) 40. SERVICE FACILITY LOCATION INFORMATION 41. BILLING PROVIDER INFO & PAYER

1 2 3 4 5 6

PATIENT AND INSURED INFORMATION
 PHYSICIAN OR SUPPLIER INFORMATION

EMC Equivalent Lines 9, 9a–9d

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
9*	Other insured's Name (Last, First, Middle Initial)	2330A	NM103	Other insured last name	Name of insured for Medigap plan
	NM104		Other insured first name		
	NM105		Other insured middle name		
9a*	Other insured's policy or group number (Medigap only)	2330A	NM106	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
			NM108	Other insured identifier	Medigap: P Primary S Secondary T Tertiary
		2320	SR031	Payer responsibility	
			SR033	Insured group or policy number	Enter the insured's group or plan number
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	2330B	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	2330B	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 3/2003 (02/12)

1. MEDICARE MEDICAID TRICARE CHAMPVA OTHER HEALTH PLAN SELCA REV (LAW) OTHER

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

3. PATIENT'S ADDRESS (No. Street)

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

5. PATIENT'S RELATIONSHIP TO INSURED

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

7. INSURED'S ADDRESS (No. Street)

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

12. DATE OF SERVICE

13. NAME OF REFERRING PROVIDER OR OTHER SOURCE

14. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

15. ADDITIONAL CLAIM INFORMATION

16. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

17. DATE OF SERVICE

18. FEDERAL TAX ID NUMBER

19. SIGNATURE OF PHYSICIAN OR SUPPLIER

20. SERVICE FACILITY LOCATION INFORMATION

21. BILLING PROVIDER INFO & P#

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

YES NO

b. AUTO ACCIDENT? PLACE (State)

YES NO

c. OTHER ACCIDENT?

YES NO

Line Items 10a, 10b and 10c

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

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

Line Item 10d

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DIS OR RESERVE OTHER

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

3. PATIENT'S ADDRESS (No. Street)

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

5. PATIENT'S RELATIONSHIP TO INSURED

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

7. INSURED'S ADDRESS (No. Street)

8. INSURED'S POLICY OR GROUP NUMBER

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

10. OTHER CLAIMS (Designated by NUCC)

11. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. PHYSICIAN OR SUPPLIER SIGNATURE

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

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 (Designated by NUCC)

20. OFFICE LAMP

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BILLING PROVIDER INFO

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO

10d. CLAIM CODES (Designated by NUCC)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SEVERELY DISABLED OTHER % INSURED'S ID NUMBER (For Programs in Item 1)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

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

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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 OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 14. OTHER DATE QUAL. 15. OTHER DATE QUAL. 16. DATE OF BIRTH AND NUMBER (If work in relevant occupation)

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABORATORY 21. PHYSICIAN CODE ORIGINAL REF. NO. 22. PRIOR AUTHORIZATION NUMBER

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

24. A. DATE OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS F. CHARGE G. ICD-9-CM H. ICD-9-CM I. PROVIDING PROVIDER'S #

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 INCLUDING ADDRESS OR CREDIT DETAILS (If bills to the insurer or to insurer apply to the bill and set it with a post office)

32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAYER ()

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 payors are known to potentially be involved in paying this claim.
			2320	SBRO3	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	
			NM109	Insured's identifier	
		2000B or 2320	SBR05	Insurance Type Code	
				Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"	
		2300	CLM01	Claim submitter's identifier	
			CLM02	Monetary amount	
		2320	AMT01	Amount qualifier code = D	
			AMT02	Monetary amount (Primary Paid Claim Level)	
		2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)	
			CAS02	Claim adjustment reason codes	
			CAS03	Adjustment amount	
			CAS04	Adjustment quantity	
		2330B or 2430	DTP01	Primary insurance adjudication date	
DTP02	Date time period qualifier				
DTP03	Date paid				

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

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

Line Item 12

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (Medicare) (Medicaid) (Tricare) (Champion) (Group Health Plan) (Other)

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

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code) () () 6. PATIENT RELATIONSHIP TO INSURED (Self, 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 PATIENT'S CONDITION RELATED TO: (Employment, Auto Accident, Other Accident) 10. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes, No, Other)

11. INSURED'S POLICY OR GROUP OR FICA 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. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 16. 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.) 17. SIGNED DATE 18. SIGNED DATE

19. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Name, Address, City, State, Zip, Phone) 20. HOSPITAL/CLINICAL DATES RELATED TO CURRENT SERVICES (From, To) 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 22. OUTPATIENT? (Yes, No) 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (From, To) B. PLACE OF SERVICE (Office, Home, Other) C. PROCEDURE, SUPPLIER, OR SUPPLIER (CPT/HCPCS, ICD-9-CM, ICD-10) D. DIAGNOSIS (ICD-9-CM, ICD-10) E. CHARGE(S) F. TOTAL CHARGE G. AMOUNT PAID H. RELEASED BY (Name, Title, Signature)

25. FEDERAL TAX ID NUMBER (SSN, EIN) 26. PATIENT'S ACCOUNT NO. 27. IS CLAIM ASSIGNMENT? (Yes, No) 28. BILLING PROVIDER INFO & P/F ()

29. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this claim apply to the bill and are under a part thereof)) 30. SERVICE FACILITY LOCATION INFORMATION 31. BILLING PROVIDER INFO & P/F ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

PCIA

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

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

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

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)

7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PRESENT CONDITION RELATED TO (a. EMPLOYMENT (Current or Previous) YES/NO, b. AUTO ACCIDENT? YES/NO, c. OTHER ACCIDENT? YES/NO)

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM, DD, YY) QUAL (Qualification)

15. OTHER DATE (MM, DD, YY) QUAL (Qualification)

16. OTHER CAUSE AND NUMBER (Work-Related Occupational Injury)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MD, DO, NP, PA)

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE CLAIM (YES/NO) & CHARGE

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

22. PRESCRIPTION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE (From, To, PLACE OF SERVICE, EMPLOYER) B. PROVIDER, SUPPLIER, OR SUPPLIER (Special, Unlicensed, Out-of-State, Medicare) C. PHYSICIAN IDENTIFICATION NUMBER D. CHARGE E. CHARGE F. DATE OF SERVICE G. ICD-9-CM H. REFERRING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE

29. AMOUNT PAID

30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address of office unless it differs from the claimant's or the insurer's apply to the SE and set it with a post office)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

PHYSICIAN OR SUPPLIER INFORMATION

Line Item 13

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

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

Line Item 14

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/00 0012

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

15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD TO MM DD YY

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

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

18. INSURED'S POLICY OR GROUP OR POLICY NUMBER

19. EMPLOYMENT (Current or Pending)
A. YES NO
B. AUTO ACCIDENT? PLACE (DATE)
C. OTHER ACCIDENT?
D. CLAIM CODES (Designated by NCCI)

20. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO (If yes, complete Item 16, 19, 20.)

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

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

23. SERVICE FACILITY LOCATION INFORMATION

24. BILLING PROVIDER INFO & PFI# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN DECA/NOV (LEAD) 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									
5. PATIENT'S ADDRESS (No. Street)										6. PATIENT RELATIONSHIP TO INSURED									
CITY					STATE					7. INSURED'S ADDRESS (No. Street)					8. INSURED'S NAME (Last Name, First Name, Middle Initial)				
ZIP CODE					TELEPHONE (Area Code)					9. RESERVED FOR NUCC USE					10. IS PRESENT CONDITION RELATED TO				
3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR POLICY NUMBER									
4. OTHER INSURED'S POLICY OR GROUP NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY SEX									
5. RESERVED FOR NUCC USE										13. OTHER CLAIM (Designated by NUCC)									
6. RESERVED FOR NUCC USE										14. INSURANCE PLAN NAME OR PROGRAM NAME									
7. RESERVED FOR NUCC USE										15. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
8. INSURANCE PLAN NAME OR PROGRAM NAME										16. IS 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.									
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE									
19. SIGNATURE DATE										20. SIGNATURE DATE									
21. STATE OF CURRENT RESIDENCE (State, County, or Precinct)										22. DATE AND NUMBER TO WORK IN CURRENT OCCUPATION									
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE										24. MEDICAL DATES RELATED TO CURRENT SERVICES									
25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										26. OUTSIDE LAB \$ CHARGE									
27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL in separate boxes)										28. PHYSICIAN CODE ORIGINAL REF NO.									
29. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. PHYSICIAN IDENTIFICATION E. CHARGE F. ICD-9-CM G. QUAL. H. PROVIDING PROVIDER ID #										30. PRIOR AUTHORIZATION NUMBER									
1										2									
2										3									
3										4									
4										5									
5										6									
6										7									
25. FEDERAL TAX ID NUMBER										26. PATIENT'S ACCOUNT NO.									
27. ACCOUNT ASSIGNMENT?										28. TOTAL CHARGE									
29. SIGNATURE OF PHYSICIAN OR SUPPLIER										30. SERVICE FACILITY LOCATION INFORMATION									
31. BILLING PROVIDER INFO & PAY ()										32. BILLING PROVIDER INFO & PAY ()									

15. OTHER DATE
QUAL. MM DD YY

Line Item 15

- Not required
- Not mapped electronically

Line Item 16

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

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

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (MR/MRS/MS/MISS/DR/OTHER) 7. INSURED'S ADDRESS (No. Street)
 CITY STATE ZIP CODE TELEPHONE (provide Area Code) OFF CITY STATE ZIP CODE TELEPHONE (provide Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PHYSICIAN'S CONDITION RELATED TO (YES/NO) 10. INSURED'S POLICY OR GROUP OR FICA NUMBER
 11. EMPLOYMENT (Current or Previous) (YES/NO) 12. AUTO ACCIDENT? (YES/NO) PLACE (State) 13. OTHER CLAIM? (One paid by MUO) (YES/NO)
 14. RESERVED FOR MUO USE 15. OTHER ACCIDENT? (YES/NO) 16. INSURANCE PLAN NAME OR PROGRAM NAME 17. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) (If yes, complete item 18, 19, and 20)
 18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (authorize the release of any medical or other information necessary to process this claim. Also request payment of government benefits to be paid to the party who accepts assignment below) 19. DATE 20. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) (If yes, complete item 21, 22, and 23)

21. DATES OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Last) 22. OTHER DATE (MM/YY) 23. NAME OF REPORTING PROVIDER OR OTHER SOURCE (Last, First, Middle Initial) 24. ADDITIONAL CLAIM INFORMATION (Designated by MUO) 25. OFFICIAL LAST NAME (Last, First, Middle Initial) 26. CHARGE(S)
 27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Nonspecific ICD-9-CM codes for injury, ICD-9-CM codes for diagnosis) 28. PHYSICIAN OR OTHER PROVIDER'S ORIGINAL REPORT NO. 29. PRIOR AUTHORIZATION NUMBER
 30. A. DATE OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE (IHS, NPI, etc.) C. PROCEDURE, SUPPLY, OR SERVICE (ICD-9-CM procedure code, ICD-9-CM diagnosis code, ICD-9-CM procedure code, ICD-9-CM diagnosis code) D. DIAGNOSIS (ICD-9-CM diagnosis code) E. CHARGE(S) F. PHYSICIAN OR OTHER PROVIDER'S ID # G. QUAL. H. PROVIDING PROVIDER'S ID #

31. FEDERAL TAX ID NUMBER 32. PATIENT'S ACCOUNT NO. 33. ACCIDENT ASSIGNMENT? (YES/NO) 34. TOTAL CHARGE \$ 35. AMOUNT PAID \$ 36. RESERVED FOR MUO USE
 37. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials (I certify that the statements on this claim apply to this bill and are made a part thereof)) 38. SERVICE FACILITY LOCATION INFORMATION 39. BILLING PROVIDER INFO & PAYER ()

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0212

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

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

3. PATIENT'S BIRTH DATE MM/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 POLY NUMBER

12. OTHER INSURED'S POLICY OR GROUP NUMBER

13. EMPLOYMENT (Current or Former)

14. INSURED'S DATE OF BIRTH MM/YY SEX

15. RESERVED FOR NUCC USE

16. AUTO ACCIDENT? YES NO PLACE (State)

17. OTHER CLAIM? (Pre-qualified by NUCC)

18. RESERVED FOR NUCC USE

19. OTHER ACCIDENT? YES NO

20. INSURANCE PLAN NAME OR PROGRAM NAME

21. IS CLAIM CODES (Designated by NUCC)

22. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Form 1, 1A, 1000)

23. 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.

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

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

26. OTHER DATE

27. DATE(S) RELATED TO CURRENT SERVICES

28. NAME OF REFERRING PROVIDER OR OTHER SOURCE

29. NPI

30. DATES RELATED TO CURRENT SERVICES

31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

32. PHYSICIAN CODE

33. PRIOR AUTHORIZATION NUMBER

34. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SUPPLIER, OR SUPPLIER D. DIAGNOSIS E. CHARGE F. DATE G. QUANTITY H. PROVIDING PROVIDER ID #

35. FEDERAL TAX ID NUMBER

36. PATIENT'S ACCOUNT NO

37. ACCOUNT ASSIGNMENT? YES NO

38. TOTAL CHARGE

39. AMOUNT PAID

40. RESERVED FOR NUCC USE

41. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OF CARE (unless it differs from the address to be billed) apply to the 34 and set it with a post office

42. SERVICE FACILITY LOCATION INFORMATION

43. 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

- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

PCIA

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN OTHER NO (USED) YES (USED) 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 (Self 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 PRESENT CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. IS THIS CLAIM FOR AUTO ACCIDENT? YES NO

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM DD YY)

15. OTHER DATE (MM DD YY)

16. DATE OF BIRTH AND NUMBER TO WORK IN CURRENT OCCUPATION (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN) (17a) (17b) (17c) (17d) (17e) (17f) (17g) (17h) (17i) (17j)

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. PRESCRIPTION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

23. A. CARRIER OF SERVICE From (MM DD YY) To (MM DD YY) B. PLACE OF SERVICE (ICD-9-CM) C. PROVIDER, SUPPLIER, OR SUPPLIER (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGE (ICD-9-CM) F. ICD-9-CM G. ICD-9-CM H. ICD-9-CM I. ICD-9-CM J. ICD-9-CM

24. FEDERAL TAX ID NUMBER (SSN) (24a) (24b) (24c) (24d) (24e) (24f) (24g) (24h) (24i) (24j) (24k) (24l) (24m) (24n) (24o) (24p) (24q) (24r) (24s) (24t) (24u) (24v) (24w) (24x) (24y) (24z)

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office unless it differs from the address on the reverse apply to the SE and set it with a post office)

26. SERVICE FACILITY LOCATION INFORMATION

27. 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 CHRYSLER GROUP HEALTH PLAN IS OR NOT COVERED 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 (301 or Area Code) CITY STATE ZIP CODE TELEPHONE (301 or Area Code)

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

11. INSURED'S DATE OF BIRTH MM DD YY SEX 12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of all medical or other information necessary to process this claim. I also request payment of government benefits other than just D to the party who accepts assigned claim.) 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 14, and 15.)

14. DATE OF CURRENT SURGICAL INJURY, IF PROGRAMMATIC CARE 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 21. PHYSICIAN CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

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

24. FEDERAL TAX ID NUMBER 25. PATIENT'S ACCOUNT NO. 26. TOTAL CHARGE 27. AMOUNT PAID 28. BILLING PROVIDER INFO & Print ()

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (Verify that the signature or credentials apply to the bill and are valid & not expired.) 30. SERVICE FACILITY LOCATION INFORMATION 31. 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 CHIP/STPA GROUP HEALTH PLAN SELF OR OTHER OTHER

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

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

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

5. PATIENT RELATIONSHIP TO INSURED

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

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

8. OTHER INSURED'S POLICY OR GROUP NUMBER

9. EMPLOYMENT (Date of Prevalence)

10. IS PHYSICIAN'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR POLICY NUMBER

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

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

14. DATE OF CLAIM (Current Injury, Illness, or Pregnancy Date) QUAL

15. OTHER DATE (MM DD YY) QUAL

16. DATE OF BIRTH (Current in Current Occupation) (MM DD YY) OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITAL DATE-ON-DATE(S) RELATED TO CURRENT SERVICES (MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Nausea, All, Enter the ICD-9-CM CODES)

22. PRIOR AUTHORIZATION NUMBER

23. FEDERAL TAX ID NUMBER (SRI 254)

24. PATIENTS ACCOUNT NO

25. TOTAL CHARGE \$

26. AMOUNT PAID \$

27. FEDERAL TAX ID NUMBER (SRI 254)

28. PATIENTS ACCOUNT NO

29. ACCRUE ASSIGNMENT? (YES/NO)

30. SERVICE FACILITY LOCATION INFORMATION

31. BILLING PROVIDER INFO & PFI# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN OTHER (See Instructions) 14. 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 8. RESERVED FOR NUCC USE CITY STATE

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

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

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

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD-10 Ind. 22. PREVIOUS CLAIM CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FROM	TO	DATE OF SERVICE	PROVIDER	ICD-10 CODE	ICD-10 INDICATOR	NONCLAIM PROVIDER #
MM	DD	YY	MM	DD	YY	
1						
2						
3						
4						
5						
6						

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials if bills to the insurer or to a reinsurer apply to the bill and set it with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Item 21

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

EMC Equivalent Line 21

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



Line Item 22

- Not required
- Not mapped electronically

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

PCIA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHIP/PA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> SELF OR RETIRED <input type="checkbox"/> OTHER <input type="checkbox"/>		16. 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/YY) SEX (M/F)		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other)		9. OFFICE	
CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)		CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR POLICY NUMBER	
A. EMPLOYMENT (Current or Previous) YES/NO		12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
B. AUTO ACCIDENT? YES/NO PLACE (State)		13. OTHER CLAIMS (Designated by NUCC)	
C. OTHER ACCIDENT? YES/NO		14. INSURANCE PLAN NAME OR PROGRAM NAME	
15. IS CLAIM CODES (Designated by NUCC)		17. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES/NO (If yes, complete Item 16, 18, and 19)	
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 this claim to the party who accepts assignment below.)			
SIGNED		SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, OR PROGRAMMATIC CLAIM (MM/DD/YY) QUAL		15. OTHER DATE (MM/DD/YY) QUAL	
17. NAME OF REPORTING PROVIDER OR OTHER SOURCE (SSN/ID) (Print Name)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO) (MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OFFICE LAMP # CHANGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From A-C, Everlasting Index D-18) (ICD-9-CM)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATES OF SERVICE (From/To) (MM/DD/YY - MM/DD/YY) B. PLACE OF SERVICE (C. ICD-9-CM) D. PROVIDER, SUPPLIER, OR SUPPLIER (E. Designation of Relationship) F. CHANGES G. TYPE OF SERVICE H. PROVIDING PROCESSOR ID #			
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX ID NUMBER (SSN/ID) 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 (Include degrees or credentials (Verify that the signature or credentials apply to the SE and are valid a part below))		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO # Print ()	

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN OTHER	14. 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) 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. IS PRESENT CONDITION RELATED TO:	10. INSURED'S POLICY GROUP OR POLICY NUMBER
9. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT (Current or Previous)	11. INSURED'S DATE OF BIRTH (MM DD YY) SEX
10. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	12. OTHER CLAIMS (Prepaid by NUCC)
11. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? PLACE (State)	13. INSURANCE PLAN NAME OR PROGRAM NAME
12. INSURANCE PLAN NAME OR PROGRAM NAME	13. CLAIM CODES (Designated by NUCC)	14. IS THERE ANOTHER HEALTH BENEFIT PLAN?
15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits other than my own to the party who accepts assignment below.		
16. STATE OF CURRENT RESIDENCE (MM DD YY) QUAL	17. OTHER DATE (MM DD YY) QUAL	18. DATE OF BIRTH (MM DD YY) WORK-RELATED OCCUPATION
19. NAME OF REFERRING PROVIDER OR OTHER SOURCE	20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	21. OUTSIDE LAB? \$ CHARGE
22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	23. PRIOR AUTHORIZATION NUMBER	24. PHYSICIAN OR SUPPLIER INFORMATION
25. FEDERAL TAX ID NUMBER	26. PATIENT'S ACCOUNT NO.	27. ACCOUNT ASSIGNMENT? YES NO
28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Includes address of office unless it differs from the address on the reverse apply to the SE and set it with a post office)	29. SERVICE FACILITY LOCATION INFORMATION	30. BILLING PROVIDER INFO & PAY ()

Line Item 23

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

EMC Equivalent Line 23

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00 0012

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN DECA/DCO OTHER
 Medicare Medicaid Tricare CHIP/VA Group Health Plan Deca/DCO 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 (Self 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 PRESENT 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 GROUP OR POLICY NUMBER
 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)
 13. OTHER CLAIM# (Designated by NUCC)
 14. INSURANCE PLAN NAME OR PROGRAM NAME
 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete form 9, 10, 11, 12)
 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 insurance credits either to myself or to the party who accepts assigned claim.
 17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the authorized physician or supplier for services described below.
 18. DATE SIGNED
 19. DATE SIGNED
 20. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN (MM DD YY) (17a) (17b) (17c) (17d)
 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
 23. OUTSIDE LAB? YES NO
 24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 60 days) A B C D
 25. PHYSICIAN CODE ORIGINAL REF NO.
 26. PRIOR AUTHORIZATION NUMBER

Line Items 24A-24J

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

LINE	DATE OF SERVICE	PLACE OF SERVICE	CPT/HCPCS	DIAGNOSIS	CHARGE	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 OTHER 14. INSURED'S ID NUMBER (For Programs in Item 1)

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

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

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

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

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

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

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

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. C. D. PROVIDER, SUPPLIER, OR SUPPLIER B. D. H. J. K. L. P. Q. R. S. T. U. V. W. X. Y. Z. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID. NUMBER SSN EIN

26. ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVED FOR 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 CHRYSLER GROUP HEALTH PLAN SELF OR RETIRED OTHER

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

3. PATIENT'S ADDRESS (No. Street)

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

5. PATIENT'S RELATIONSHIP TO INSURED

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

7. INSURED'S ADDRESS (No. Street)

8. INSURED'S POLICY GROUP OR POLICY NUMBER

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

10. INSURED'S EMPLOYMENT (Current or Former)

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 PREGNANCY (MM/DD/YY)

15. OTHER DATE (MM/DD/YY)

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

17. NAME OF REPORTING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OFFICE LAMP

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

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (FROM TO)

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. SIGNATURE OF PHYSICIAN OR SUPPLIER

29. BILLING PROVIDER INFO

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2002

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

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

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

CITY STATE 8. RESERVED FOR MUCC USE CITY STATE

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

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

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

14. DATE OF CURRENT CLAIM (Month, Day, Year) 15. OTHER DATE (Month, Day, Year) 16. DATE OF AND UNDER (Work-Related) 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 MUCC) 20. OUTSIDE LAB? \$ CHARGE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events in the last 12 months) 22. PRESCRIPTION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS E. CHARGE F. DATE 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. 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. 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 27. ACCEPT ASSIGNMENT? (For PHL claims, see page 9999) 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVE MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office or facility if different than the address to be billed) 32. SERVICE FACILITY LOCATION (If different) 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) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (See Instructions)

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

8. OTHER INSURED'S NAME (Last, First, Middle Initial) 9. IS THIS CLAIM RELATED TO: YES NO

10. IS THIS CLAIM RELATED TO: YES NO

11. INSURED'S POLICY OR GROUP NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits due to myself or to the party whose name is assigned below.) DATE

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

14. DATE OF CURRENT SURGICAL INJURY, IF PREVIOUSLY LOST 15. CLAIM DATE (MM/DD/YY) 16. DATE OF SERVICE (MM/DD/YY)

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events relative to this claim)

22. PRESCRIPTION CODE ORIGINAL REF. NO.

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. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials if entity that the statement or the charges apply to the bill and on trade a part thereof)

28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 2005 (02)

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

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 LAST WORK-RELATED OCCUPATION

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 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER D. CHARGE E. CHARGE F. CHARGE G. CHARGE H. CHARGE I. CHARGE J. CHARGE

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 INVOICE

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

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

32

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

1. MEDICARE MEDICAID TRICARE CHIP/VA MEDICARE HEALTH PLAN (HMO) 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 DATE OF BIRTH (MM DD YY)

9. PATIENT'S SEX (M F)

10. PATIENT'S RELATIONSHIP TO INSURED

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

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Provide Area Code)

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

18. OTHER INSURED'S POLICY OR GROUP NUMBER

19. EMPLOYMENT (Current or Former)

20. EMPLOYER'S NAME

21. EMPLOYER'S ADDRESS (No. Street)

22. CITY

23. STATE

24. ZIP CODE

25. TELEPHONE (Provide Area Code)

26. DATE OF CLAIM (MM DD YY)

27. DATE OF SERVICE (MM DD YY)

28. PLACE OF SERVICE (P)

29. PROCEDURE, SUPPLY OR SUPPLIER (C)

30. DIAGNOSIS (ICD-9-CM)

31. CHARGE (A)

32. AMOUNT PAID (B)

33. REVENUE (C)

34. SIGNATURE OF PHYSICIAN OR SUPPLIER

35. BILLING PROVIDER INFO & PAYER ()

36. SERVICE FACILITY LOCATION INFORMATION

37. NPI

38. NPI

39. NPI

40. NPI

41. NPI

42. NPI

43. NPI

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83. NPI

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86. NPI

87. NPI

88. NPI

89. NPI

90. NPI

91. NPI

92. NPI

93. NPI

94. NPI

95. NPI

96. NPI

97. NPI

98. NPI

99. NPI

100. NPI

HEALTH INSURANCE CLAIM FORM

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

HEALTH INSURANCE CLAIM FORM (Form 1010-UB) APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN DECA/RYLIFE 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. IS PRESENT CONDITION RELATED TO
10. EMPLOYMENT (Current or Former) a. YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO
11. INSURED'S POLICY GROUP OR FICA NUMBER
12. INSURED'S DATE OF BIRTH MM DD YY SEX
13. OTHER CLAIM (Previously by NUCC)
14. INSURANCE PLAN NAME OR PROGRAM NAME
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO
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 after it is paid to the party who is appropriately assigned below.
17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below.
18. DATE SIGNED
19. OTHER DATE QUAL MM DD YY
20. OTHER (Last Name, First Name, Middle Initial) WORK OR CURRENT OCCUPATION (Job Title) (Code) () TO ()
21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
22. OUTSIDE LAB? YES NO CHARGE \$
23. PRIOR AUTHORIZATION NUMBER
24. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. DIAGNOSIS 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. 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. 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 SSN EIN
26. SERVICE FACILITY LOCATION INFORMATION
27. TOTAL CHARGE 28. AMOUNT PAID 29. FINDER'S FEE
30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address or office address if different than address of the provider or the service facility and include a print name.)
31. BILLING PROVIDER INFO & PAY ()
A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 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. 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. 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.

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
		2420C**	NM109 (ZZ)	
		2400	PS101	Purchased service provider identifier
		2420U	NM108	Identification code qualifier =00
			NM109	Identification code =XX
			NM101	Identification code qualifier =0R
			NM108	Identification code
			NM109	Identification code
			REF01	Reference Identification qualifier =LW
REF02	Mammogram FDA number			
Enter the NPI of the Service Facility. Enter "XX" in the NM108 to indicate the NPI is present in the NM108.				

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	PER02	Provider state	Enter the provider or service/supplier's billing name, address, zip code and telephone number. Must be a physical address with nine-digit ZIP code.
			PER03	Provider ZIP code	
			PER04	Provider phone number	
			NM109 (85)	Provider ID	
33b	Billing Taxonomy Number	2005A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PKC

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE, SEX
 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. INSURED'S BIRTH DATE, SEX

6. PATIENT'S ADDRESS (No. Street) 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 (Date of Termination)
 11. INSURED'S POLICY GROUP OR PLAN NUMBER 12. INSURED'S DATE OF BIRTH, SEX

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S CLAIM 15. CLAIM DATE
 16. DATE OF BIRTH, SEX, OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTPAT LAST CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes below) 22. PRESCRIPTION CODE ORIGINAL PREP. NO.
 A. B. C. D. E. F. G. H. I. J. K. L.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO
 28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address and telephone number. If copy, certify that the statement or the reverse apply to this bill and use it with a part billed.) 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](#)

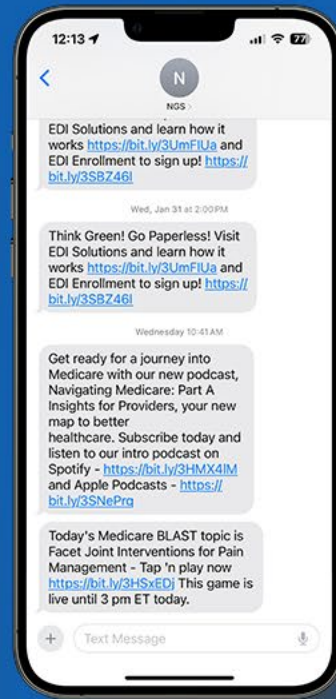
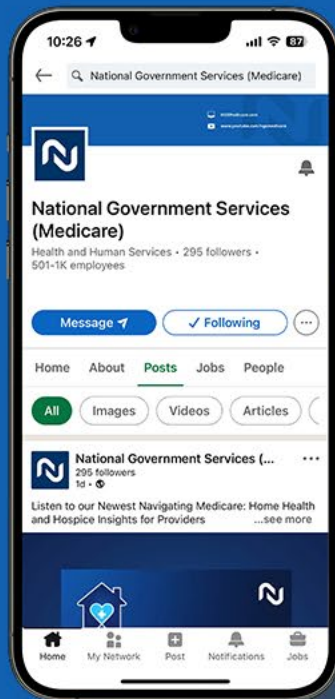
Resources, References and Tools

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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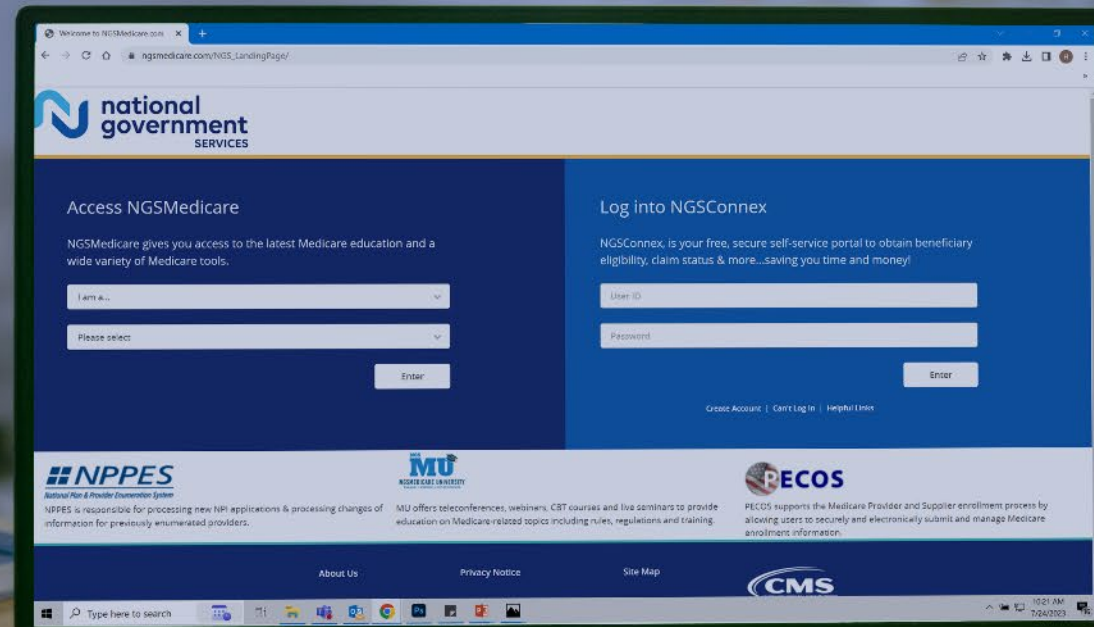
medicare **mobile**

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Web portal for claim information



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