



# 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** 

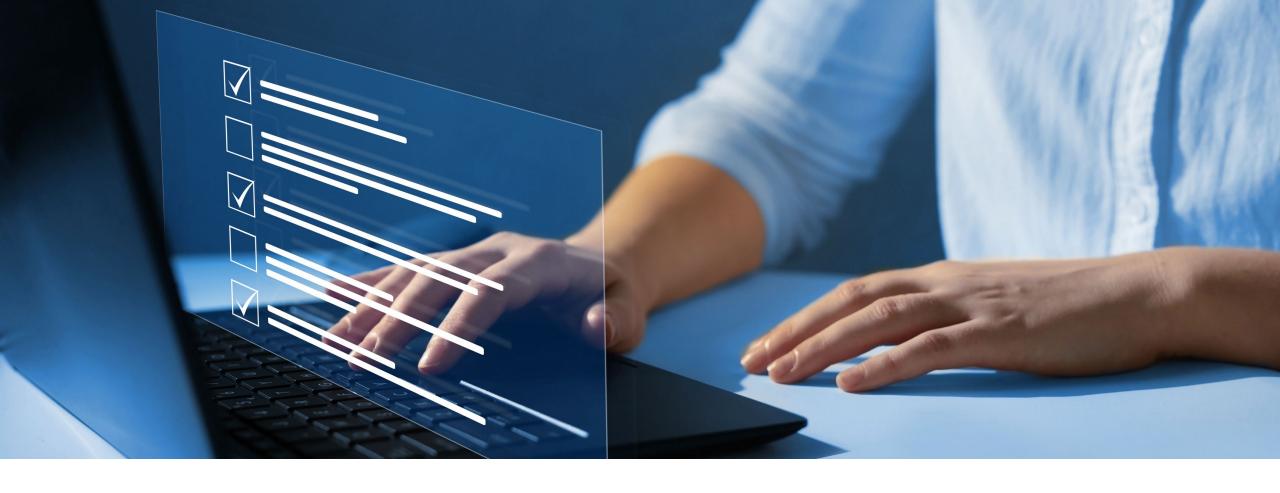
- Arlene Dunphy, CPC
- Carleen Parker









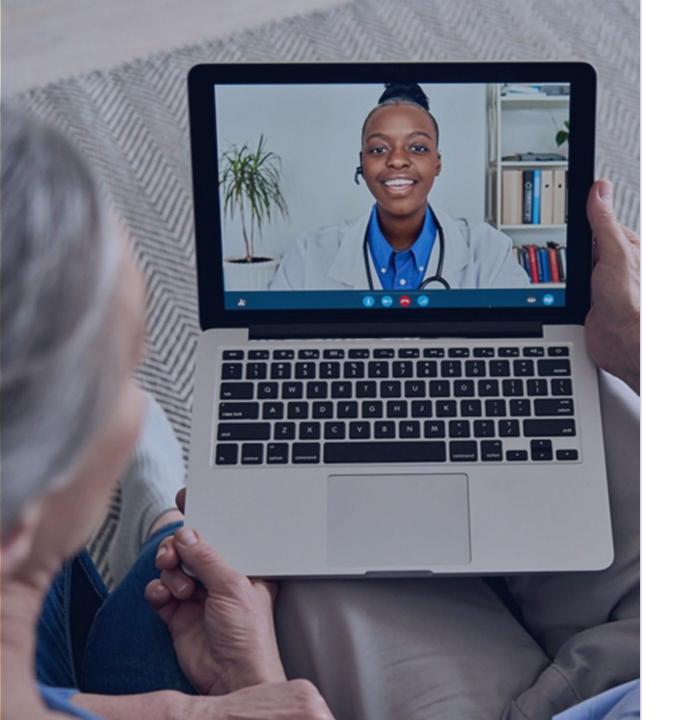


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## Recording

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

- <u>Claim Form Requirements</u>
- <u>Time Limits for Filing Medicare Claims</u>
- <u>Claim Form Overview</u>
- 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® <u>MM7270 Revised: Changes to the Time Limits for Filing Medicare Fee-For-Service Claims</u>
  - Administrative error
  - Retroactive Medicare entitlement, including when State Medicaid agencies involved
  - Retroactive disenrollment from Medicare Advantage Plan or PACE Provider Organization

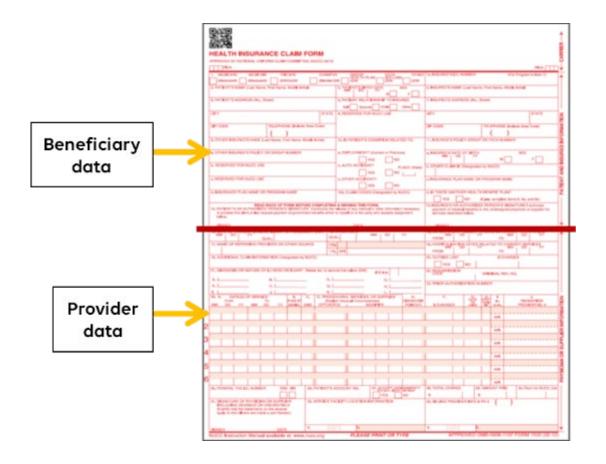






# Claim Form Overview

# CMS-1500 Claim Form (02/12)



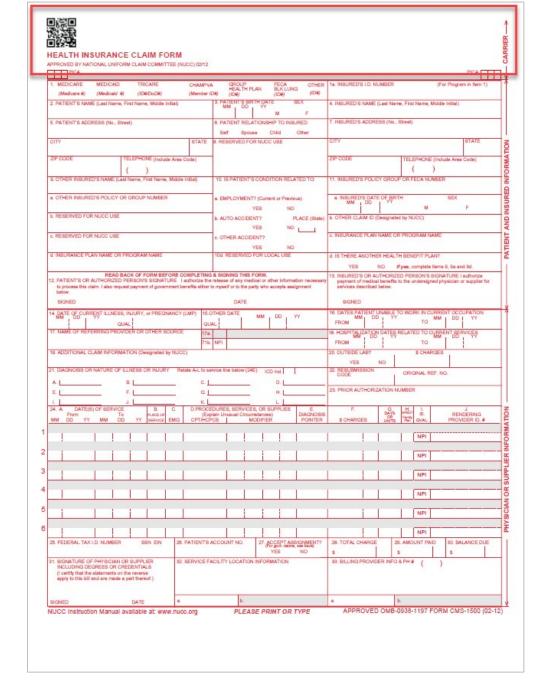






## **NUCC Approved OMB**

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







#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNIFORM CLAMICOMMETTER SALICID 62/12 MEDICARE MEDICAID TRICARE CHAMPVA (ID#/DoD#) (Member ID#) (Medicaid#) (ID#) 5. PATIENT'S ACCOMESS INC., Street O PATIENT HILLAT CHOICE TO HISUPED INSURED S ADDRESS DO STORE Sign Spouse Otto Other STATE 9. RESERVED FOR MUCC USE TRILLIPACION INCIDE Res Como SLEPHONE (Include Avea Codo) 9. OTHER INSURED/S NAME 6,set Name, First Name, Missle Initials A. EMPLOYMENTS (Current or Pro-40xis) a. OTHER INSURED'S POLICY OR GROUP IS MEET D. PRINKRY FOR MUCC USE S AURO ACCORDING? D. OFHER CLASS ID (Designated by NVCC) E RESERVED FOR NUCCUSE OTHER ACCIDENTS INSURANCE PLAN NAME OF PROSPUBLINAM 180 4. MEUTANCE PLAN NAME OF PROCESS NAME 100 CLAM CODES (Designated by NUCC) C. IS THERE ANOTHER HEALTH GENERAL PLANT HO Byes complete bens 9, 9a, and 90. BEAD BACK OF FORM REFORM COMPLETING & BISNING BIRSTOR PUSUPEDIS OR AUTHORIZED PERISONS SIGNATURE I WEIGHT 12 PATIENTS OF AUTHORICED PERSONS SIGNATURE LEastwice the research of any method or other information receiving premart of medical benefits to the undersigned physician or supplier for its process five darw. I also request payment of government to reflets after to regall to the party-who accepts as spriment services described below WE DETERMINED YOURSE TO WORK IN CLEENING OCCUPATION QUAL OUNC 7. HANGE OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFOFMATION (Designated by NUCC) BALISCHETUD D REMAIN MORES RONTING ROUTE ES BONDO BNO CHOMORY DS FEDERAL TAX 10: HUMBER SG. Revalidy NUCC Use 7773 SE SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OF CREDENTINGS dicards that the statements on the reverse apply to this fall and are wade a part thereof )

#### Line Item 1

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

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





#### Line Item 1a

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

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





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## 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

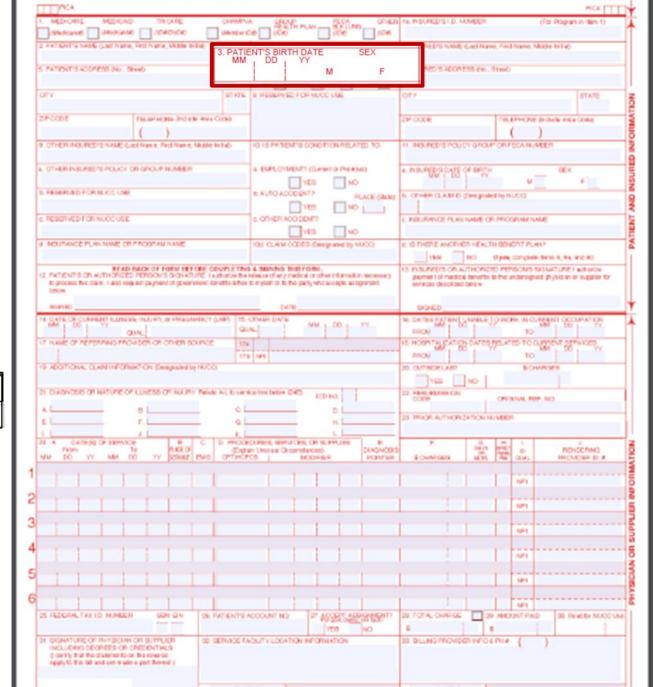
	Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	2	Patient's Name or	2010BA	NM103 NM104	Last Name First Name	Enter the patient's name as shown on their Medicare card
	2		2010CA	NM105	Middle initial	
ı			2010011	NM107	Suffix (e.g., Jr. Sr.)	



## 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 NACIONAL UNIFORM CLAIM COMMITTED SALCO; 00312





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- 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											
	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)		NM103	Other insured last name	Enter the insured's name. Required if any other payers are											
4*			2330A	2330A	2330A	2330A	2330A	2330A	2330A	2330A	2330A	2330A	2330A	NM104	NM104 Other insured first name	known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information
			NM105	Other insured middle name	reported in the 2010BA Loop does not repeat in the 2330A Loop.											





- 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											
			N301	Subscriber address line 1												
1 1	Defects address and	2010BA	2010BA											N302 Subscriber	Subscriber address line 2	
5	Patient's address and telephone number			N401	Subscriber city name	Enter the patient's mailing address										
1 1	telephone number		N402	Subscriber state												
			N403	Subscriber ZIP code												

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## 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 litem only when litems 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	



- 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	
			N301	Other subscriber address line 1	Enter the mailing address of the insured. Required if other	
	Insured's address and telephone number (Complete this MSP claims)		N302	Other subscriber address line 2	payers are known to potentially be involved in paying this claim	
7*		this MSP 2330A	2330A N401	N401	Other subscriber city name	and the information is available. If the insured is the patient this
			N402	Other subscriber state code	would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.	
			N403	Other subscriber ZIP code		





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#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNPOPMICLAMICOMMETTER SELECTIONS (Medicanal) (Medicanal) (CADICA) 2. PIXTERITY NAME (Last Name, First Name, Mixte Initial EVELYEEPS NAME & act Name, First Name, Motte Iv140. 5. PATIENT'S ACCRESS INC., SINNS S PATRINT HILLATICHER FO TRIBUTED INSURED SADORESS DO STOKE Ser Sexus Chief One RESERVED FOR NUCC USE 30000E TRUMP HORSE Bridge Read Co. 16.EPHONE DICINIO AVEA CORO. OTHER INSURED/S NAME Guel Name, First Name, Modile I AL OTHER INSURED'S POLICY OR GROUP INJAMER. a. EMPLOYMENTY (Current or Provious) YES D. PRINKRYNED FOR MUCC USE. E AURO ACCORDITY D. OFHER CLAMED (the grated by INVOC) PLACE (SMN) e regenves non nuccuse CONTRACCOSTANT? I NEURANCE PLAN NAME OF PROSPAR NAME 180 4. MOUTANCE PLAN NAME OF PROGRAM NAME 100 CLAM CODES (Designated by NUCC) c. IS THERE ANCEHER HEALTH GENERIT PLAN? 190 Byes, complete terms 9, 9s, and 90 BEAD BACK OF FORM REFORM COMPLETING A BROWN BRITISHS. 12. PATENTS OF AUTHORIZED PERSONS SIGNATURE I Authorize the release of any medical or other information receiving. I PASLIFIED S OR ALTHORIZED PERSONS SIGNATURE I WHINKIN promet of medical benefits to the undersigned physician or supplier for its process this darw. I also request payment of government to refet after to reposit or the party-who accepts assignment CHINE 7 HAME OF REFERENCE PROVIDER ON OTHER SOUNCE FROM 173 191 19 ADDITIONAL CLANSINFOFMATION Congruind to NUCCI O CUTTRICIPLARD YES NO CZ PRIOREGISTO CPERNAL REP. NO. 29 PRIVATE AUTHORIZATION NUMBER CHOHODE **PICHOCHNO** YES SE SERVICE FACILITY LOCATION INFORMATION INCLUDED DEGREES OF CREDENTIALS dicartify that the statements on this revenue apply to this till and are wade a part thereof )

- 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





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# 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
	Other insured's		MM103	Other insured last name	
9*	Name (Last, First,	2330A	MM104	Other insured first name	Name of insured for Medigap plan
	Middle Initial)		MM105	Other insured middle name	
	Other insured's policy or group number (Medigae only)	2030A	NM108	Identification Code Qualifier (MI Moniber Identification Number)	Medigap policy ID
İ			MM109	Other insured identifier	Medigap
Sw*		2320	58801	Payer responsibility	P Primary 5 Secondary T Tertary
			28R03	Insured group or policy number	Enter the insured's group or plan number
96*	Other insured's date of birth and sex				
	Employer's name or	were or	N401	Other payor city name	Enter the city, state and ZIP code of the insurer. Required if any
560	school name (Medigap	23308	14402	Other payer state code	other payers are known to potentially be involved in paying this claim.
	Address)		14403	Other payer ZIP code	
96"	ineurance plan name or program name	20305	MM108	Other payer identification Code Qualifier	Medigap plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	



#### HEALTH INSURANCE CLAIM FORM (Midrania) (Midrania) (7040)040 Exitution (Control National Party Plants) Exitution (Market National Plants) S. PATIENT'S ACCPIESS INC., SEVED INSURFORM ADDRESS DO STORE TREAT HOME BY DISK WAS COME 16.8 PHICKIE DICINIO AVEN CORO OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) D. PRINCENSO FOR MIXED USE CLAM D (Designated to NUCC) b. AUTO ACCIDENT? PLACE (State) reserved non vuocuse OTHER ACCIDENT? 4. MELITANCE PLAN NAME OF PROGRAM NAME TE ANCEHOS HEALTH GONDST PLANT promet of medical benefits to the undersigned physician or supplier for its process this dark. I also request payment of government bondits either to myself or to the party-who accepts as agreement T HAME OF REFERENCE PROVIDER OR OTHER SOURCE 173 191 9. ADDITIONAL CLAIM INFOFMATION (Designated to 1970) CZ PRIOREGISTO THE NAME AND POST OFFI 23 PRIVATE AUTHORIZATION NUMBER PONCONING INCLUDING DEGREES OF CREDENTIALS dicard to that the statements on the reverse apply to this fall and are wade a part thereof?)

# 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

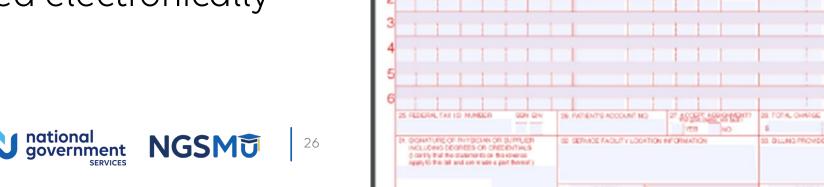
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements		
	Is patient's condition related to employment?	2300		2222	CLM11- 1	Employment related indicator (EM)	Enter the name of the Insured's other insurance
10a.	Auto Accident?				CLM11- 1	Auto accident indicator (AA)	
b, c	Place (State)		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.		

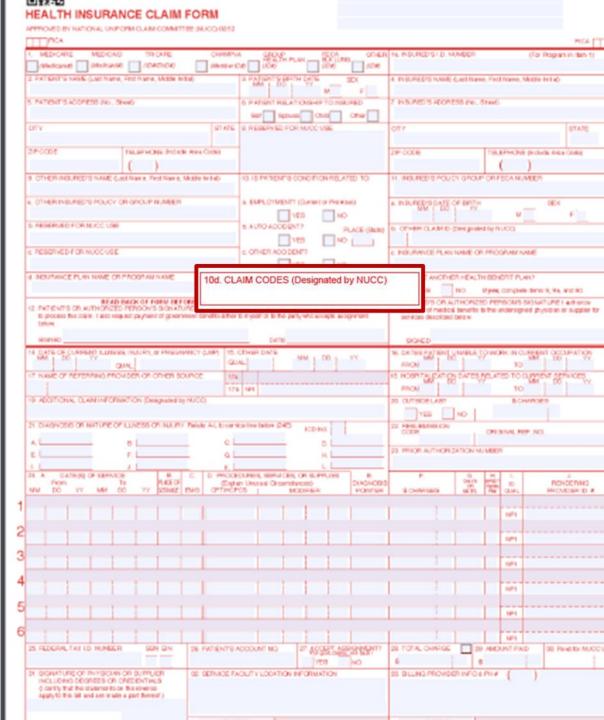




## Line Item 10d

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





#### HEALTH INSURANCE CLAIM FORM (Midrand) (Midrand) (1040)04) 2. PIXT BART'S NAME (Last Name, First Name, Middle Bridge LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches S. PATIENT'S ACCPIESS INC., Street DEPURE OF THE PROPERTY AND THE PARTY OF INSURED S ADDRESS DV. Steel Set Spruss Over Other TRUMP HORSE BYOLDS Residence Codes . INSURED'S POLICY GROUP OR FECA NUMBER 4. OTHER INSURED'S POLICY OR GROUP BLAKER A. EMPLOYMENT'S COWNES OF PREMIS OTHER CLAIM ID (Designated by NUCC) D. PRINKRYNED FOR MUCC USE E AURO ACCORDITY INSURANCE PLAN NAME OR PROGRAM NAME s, regarded from NUCCUSE OTHER ACCIDENTS 4. MEUDANCE PLAN NAME OF PROCESMINAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO If yes, complete items 9, 9a and 9d. BEAD BACK OF FORM REFORM COMPLETING A SEANING BIRD FORM. 2. PATIENT'S OR AUTHORIZED PETRODY'S SIGN ATURE 1 Authorize the release of any medical or other information. its groupes five darm. I also required payment of government tonefits either to myself or to the party-who accepts as agreement. I HAME OF REFERENCE PROVIDER OR OTHER SOURCE 173 191 9 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) O CLITHEOP LARD YES NO 2 PRIORESTON CRU CPERSON, PEP. NO. IS PRINCIPALITHORIZATION NUMBER ROYCONNO INCLUDING DEGREES OR CREDENTIALS dicards that the statements on the revenue agen, to this till and are wade a part threat?)

## 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
		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.	
		2320	SBR03	Insured Group or Policy Number	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	
			NM109	Insured's identifier	
11*	Insured policy group	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"	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to
	or FECA number	2300	CLM01	Claim submitter's identifier	potentially be involved in paying this claim.
			CLM02	Monetary amount	
		2320	AMT01	Amount qualifier code = D	
			AMT02	Monetary amount (Primary Paid Claim Level)	
			CAS01	Claim adjustment reason code (CO, PR. OA)	
		2320 or 2430	CAS02	Claim adjustment reason codes	
		2430	CAS03	Adjustment amount	
			CAS04	Adjustment quantity	
		2330B ar	DTP01	Primary insurance adjudication date	
		2430	DTP02	Date time period qualifier	
			DTP03	Date paid	

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2300 or 2400	CN102	OTAF amount	
			SVD01	Identification code	]
			SVD02	Primary payer paid amount (line level)	
			SVD03	Medical procedure identifier	]
		2430	SVD03-	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				
		2320	SBR04	Other Insured Group Name	Enter the complete insurance plan or program name
11c	11c Insurance plan name or program name	2330B	NM103	Other payer organization name	Enter the complete insurance plan name
	5. p. 5g. 311 10110	2330B	NM109	Other payer primary identifier	Enter the payer ID of the other insurer

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



- 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
	Patient's or authorized	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.
12	person's signature (Release of Information)	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.





EALTH INSURANCE CLAIM FORM			
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<ol><li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize th to process this claim. I also request payment of government benefits either below.</li></ol>	e release of any medical or other information necessary	payment of medical benefits to services described below	the indenigned physician or supplier for
SIGNED	DATE	00/60	
and to and	IAC DO YY	RROW	OWNERS OF STREET
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#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNPOPMICLAMICOMMETTER SELECTIONS (Medicanal) (Medicana) (7040)(M) 2. PIXTERITY NAME (Last Name, First Name, Mixte Initial LENGLIFEET'S NAME CLASSIFIAND, FIRST Name, Mixthe Inches 5. PATIENT'S ACCOMESS INC., Street DEPARTMENT HILLAND CHARGE TO INSURED INSURED SADORESS DO STOKE Set Space Chip Other STATE 9. RESERVED FOR MUCO USE TREATHCRE Inches Res Code 16.EPHONE DICINIO AVEA CORO. 3. OTHER INSURED/S NAME 6 set Name . First Name . Modific Initials 4. OTHER INSURED'S POLICY OR GROUP BURGER a. EMPLOYMENTY (Current or Provious). D. PRINKRYNED FOR MUCC USE. E AURO ACCIDENT? D. OFHER CLAMID (Designated by NUCC) e, regarded non vuochase OTHER ACCIDENTS I NEURANCE PLAN NAME OF PROGRAM NAME 180 4. NOUTANCE PLAN NAME OF PROOF AN NAME 100 CLAM CODES (Designated by NUCC) IS THERE ANCEHED HEALTH BEHERT PLAN? BEAD BACK OF FORM REFORM CONFIDENCE IN BRANKS BIRTORN. 12. PATIENTS OF AUTHORICED PERSON'S SIGN ATURE. Lautholds the results of any rediction of the information recessor. payment of medical benefits to the undersigned physician or supplier for services described below. its process this darw. I also request payment of government to refet after to reposit or the party-who accepts assignment 7. HAME OF REFERENCE PROVIDER OR OTHER SOURCE 173 191 19 ADDITIONAL CLAIM INFOFMATION CHISQUISES to NUCC OLITRICE LAR YES NO 2 PRIORESTON CRU CPERNAL PER NO. INTERNAL MOTOR ZWITCOM NAVABILITY **PICHOCHNO** nea 92. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS dicartify that the statements on the revenue apply to this till and are wade a part thereof;)

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

Item No.	Claim Description   I don		Field	Data Element Description	Requirements
42	Insured's or	2300	CLM09	Benefits Assignments Certification Indicator	This item authorizes payment of medical benefits to the physician.
13	Authorized Person's Signature	2320	Q103	Assignment of Benefits Indicator	N No; W Not applicable. Use code "W" when the patient refuses to assign benefits; Y Yes





- 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	
	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.	
14		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	
14		injury, pregnancy	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 HATIONAL UNIFORM CLASH COMMETTER SALICO (02/12			
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d carty that the statements on the source apply to the list and are wade a part thereof?)			

#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNPOPMICLAMICOMMETTER SELECTIONS (Medicanal) (Medicana) (7040)(M) 2. PIXTERITY NAME (Last Name, First Name, Mixte Initial EVELYEEPS NAME & act Name, First Name, Motte Iv140. 5. PATIENT'S ACCPIETO INC., SINNO O PATRINT RELATIONSHIP TO INSURED INSURED SADORESS DO STOKE Sign Signus Chip Other STATE 9. RESERVED FOR MUCC USE 30000E TREATHCRE Inches Res Code 16.EPHONE DICINIO AVEA CORO. 9. OTHER INGURED/G NAME Goot Name. First Name, Modific Inches 4. OTHER INSURED'S POLICY OR GROUP NUMBER A. EMPLOYMENTY (Current or Prowout) D. PRINKRYNED FOR MUCC USE. E AURO ACCIDENT? D. OFHER CLAMED (the grated by INVOC) PLACE (SMN) e regenves non nuccuse CONTRACCOUNTY I NEURANCE PLAN NAME OF PROSPAR NAME 150 4. NOUTANCE PLAN NAME OF PROGRAM NAME 100 CLAM CODES (Designated by NUCC) c. IS THERE ANCEHER HEALTH GENERIT PLAN? 190 Byes, complete terms 9, 9s, and 90 BEAD BACK OF FORM REFORM COMPLETING A BROWN BRITISHS. 12. PATENTS OF AUTHORIZED PERSONS SIGNATURE I Authorize the release of any medical or other information receiving. S INSURED'S OR AUTHORIZED PERSONS SIGNATURE I WENNING premart of medical benefits to the undersigned physician or supplier for its process this darw. I also request payment of government to refet after to reposit or the party-who accepts assignment 15. OTHER DATE DD , 7 HAME OF REFERENCE PROMISES ON OTHER SOUNCE 19 ADDITIONAL CLANSINFOFMATION Congruind to NUCCI YES NO 2 PRIORESTON CPERNAL REP. NO. IS PRIOR AUTHORIZATION NUMBER CHOHODE **PICHOCHNO** YES SE SERVICE FACILITY LOCATION INFORMATION INCLUDED DEGREES OF CREDENTIALS dicartify that the statements on the revenue apply to this tall and are wade a part thereof )

- Not required
- Not mapped electronically





- Not required
- Six-digit date (MM/DD/YY) or eightdigit 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
40	to work in current occupation (from and		DTP03 (360)	Initial disability period start	Enter the date(s) when patient is employed and unable to wo
16		DTP03 (361)	Initial disability period end	in current occupation. An entry here may indicate employment related insurance coverage.	





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#### HEALTH INSURANCE CLAIM FORM (Medicanal) (Medicana) (7040)(04) LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches 5. PATIENT'S ACCOMESS INC., Should IN SURFECT ADDRESS ON A THAIR Set Spruse Chic Other TRILLIP HORSE BY CHIEF Residence Commit IS APPROPRIE DECISION AND A COMO OTHER INSURED'S POLICY OR GROUP BLAKER A. EMPLOYMENTY (Current or Provious) D. PRINCENSO FOR MUCC USE E AUTO ACCODENT? D. OTHER CLASH D-CHESPHEES NUCC s, regarded from NUCCUSE 4. MOURANCE PLAN NAME OF PROCESS NAME IS THERE ANOTHER HEALTH BENEFIT PLANT READ BACK OF FORM REFORM COUPLETING & BIDNING THIS FORM. 2. PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE I Authors the release of any medical or other information recessing premark of medical benefits to the undersigned glysician or sugglier for its groupes five darm. I also required payment of government tonefits either to myself or to the party-who accepts as agreement. 2 PRIOR BARRIO CTO CPERIOR, REP. NO. 9. PRIVATE AUTHORIZATION NUMBER ROYCONNO INCLUDING DEGREES OR CREDENTIALS dicards that the statements on the reverse agen, to this till and are wade a part threat?)

#### 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





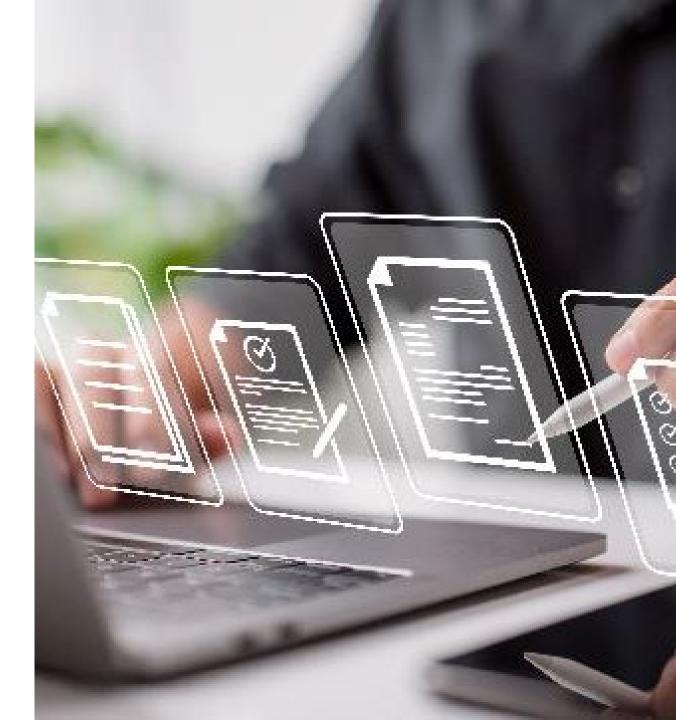
## **EMC Equivalent Lines** 17 and 17b

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

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







#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNPOPMICLAMICOMMETTER SELECTIONS (Medicanal) (Medicana) (7040)(M) 2. PIXTERITY NAME (Last Name, First Name, Mixte Initial LENGLIFEET'S NAME CLASSIFIAND, FIRST Name, Mixthe Inches 5. PATIENT'S ACCOMESS INC., Street DEPARTMENT HILLAND CHARGE TO INSURED INSURED SADORESS DO STOKE Set Space Chip Other STATE 9. RESERVED FOR MUCC USE TREATHCRE Inches Res Code 16.EPHONE DICINIO AVEA CORO. 3. OTHER INSURED/S NAME 6 set Name . First Name . Modific Initials 4. OTHER INSURED'S POLICY OR GROUP NUMBER A. EMPLOYMENTY (Current or Prowout) D. PRINKRYNED FOR MUCC USE. E AURO ACCIDENT? D. OFHER CLAMED (the grated by INVOC) e, regarded non vuochase CONTRACCOSTANT? I NEURANCE PLAN NAME OF PROGRAM NAME 180 4. MOUTHICE PLAN NAME OF PROGRAM NAME 100 CLAM CODES (Designated by NUCC) c. IS THERE ANCEHED HEALTH BEHERT PLAN? NO Byes, compate tens 9, 94, and 90 BEAD BACK OF FORM REFORM COUPLETING A BRANDS BIRD FORM. 12. PKT ENT'S OF AUTHORICED PETGODYS SIGNATURE: Lautholde the release of any medical or other information recessing. I PASLIFIED S OR ALTHORIZED PERSONS SIGNATURE I WHINKIN premart of medical benefits to the undersigned physician or supplier for its process this darw. I also request payment of government to refet after to reposit or the party-who accepts assignment CHINE 7. HAME OF REFERENCE PROVIDER OR OTHER SOURCE 173 191 19 ADDITIONAL CLAIM INFOFMATION CHISQUISES to NUCC 199 10 CZ PRIOREGISTO CPESSAL REP. NO. RESERVATING MOTHS PROHITON MOVIME OF **PICHOCHNO** rea 92. SERVICE FACILITY LOCATION INFORMATION INCLUDED DEGREES OF CREDENTIALS dicartify that the statements on the revenue apply to this till and are wade a part thereof;)

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

- 18	Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		Hospitalization dates		DTP03 (435)	Related hospitalization admission date	DTP01 Admission or Discharge qualifier 435 or 096
	18	related to current service (From and To)	2300	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





### HEALTH INSURANCE CLAIM FORM (Medicanal) (Medicana) (7040)(04) LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches 5. PATIENT'S ACCOMESS INC., Show IN SUPPLIES ADDRESS ON A FRANCE Set Spruse Chic Other TRILLIP HORSE BY CHIEF Residence Commit IS APPROPRIE DECISION AND A COMO OTHER INSURED'S POLICY OR GROUP BLAKER A. EMPLOYMENTY (Current or Provious) D. PRINCENSO FOR MUCC USE E AUTO ACCODENT? D. OTHER CLASH D-CHESPHEES NUCC s, regarded from NUCCUSE 4. MOURANCE PLAN NAME OF PROCESS NAME IS THERE ANOTHER HEALTH BENEFIT PLANT READ BACK OF FORM REFORM COUPLETING & BIDNING THIS FORM. 2. PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE. Laufleton the release of any medical or other information recessing premark of medical benefits to the undersigned glysician or sugglier for its groupes five darm. I also required payment of government tonefits either to myself or to the party-who accepts as agreement. 2 PRIOR BARRIO CTO CPERIOR, REP. NO. 9. PRIVATE AUTHORIZATION NUMBER ROYCONNO INCLUDING DEGREES OR CREDENTIALS dicards that the statements on the reverse agen, to this tall and are wade a part thereof?)

### 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 Line 19

- Loops2300/2400/2310D/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





- 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

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





ALTH INSURANCE CLAIM FORM			
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BUTANCE PLAN NAME OF PROGRAM NAME	10s CLAM CODES (Swignamers) NUCC)	C. IS THERE ANOTHER HEALTH BENEFIT	(PLRE? (SHR-BYSER, RK, MCRC)
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### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNIFORM CLAM COMMITTEE BLUCG 02/12 (Midrand) (Midrado) (7040)04) 2. PIXT BAYET'S NAME (Last Name, First Name, Mixtell British LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches 5. PATIENT'S ACCOMESS INC., Street S PATIENT RELATIONSHIP TO RESURSO INSURED S ADDRESS DV. Steel Set Spruss Over Other STATE 9. RESERVED FOR MUCO USE TRUMP HORSE BY LINE WAS CORE ISLEPHONE (Include Avea Code) 4. OTHER INSURED'S POLICY OR GROUP BURGER A. EMPLOYMENTS (Current or Provious) D. PRINKRYNED FOR MUCC USE E AURO ACCORDING? D. OTHER CLASH D-CHESPHEES NUCC e, regaring pinan nuoquae OTHER ACCIDENTS INSURANCE PLAN WARE OR PROGRAM WARE 4. MEUTANCE PLAN NAME OF PROCESMINAME OC CLAW CODES (Designated to NUCC) IS THERE ANOTHER HEALTH BENEAT PLAN? 160 If yes, complete terms 9, 94, and 90 BEAD BACK OF FORM REFORE COMPLETING A BIDANIS BIDEFORM. 2. PATERITS OF AUTHORISED PERSONS SIGNATURE I Authors to ensure of any metod or other information recessively. INSUREDIS OR AUTHORIZED PERSONS SIGNATURE I WHINKIN premark of medical benefits to the undersigned glysician or sugglier for to process this date. I also request payment of government tonefits either to myself or to the party who accepts assignment. CHINE 7. HAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFORMATION (Designated by NUCC OLITRICE LAR **BCHARGES** YES NO PRINCIPATION CO. CPERSON, PEP. NO. PRIOR AUTHORIZATION NUMBER **PONDODNO** hea SE SERVICE ENOUTY LOCATION INFORMATION INCLUDING DEGREES OF CREDENTINGS dicards that the statements on the reverse agen, to this tall and are wade a part thereof?)

- 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 <u>Claims</u>

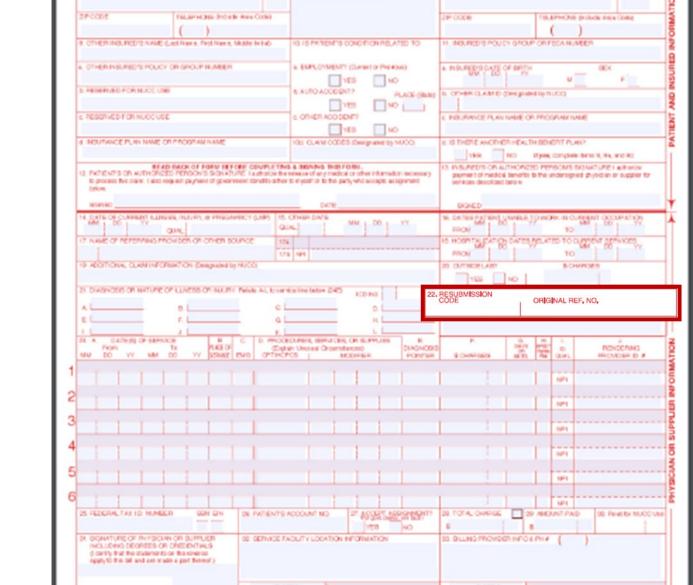






### Line Item 22

- Not required
- Not mapped electronically



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STATE IS RESERVED FOR MUCC USE

INSURED SUPPRESS PR. STeel

HEALTH INSURANCE CLAIM FORM

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5. PATIENT'S ACCOMESS INC., SENNO





### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNIFORM CLAIM COMMITTEE BLICCLOSIS (Medicanal) (Medicanal) (CAC)(CA) LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches 5. PATIENT'S ACCRESS (No., Street) S PATIENT RELATIONSHIP TO RESURSO IN SURED IS ADDRESS the J. Steel. Sign Signatura Chica Chiar STATE 9. RESERVED FOR MJOC USE TRUMP HORSE BY LINE WAS CORE ISLEPHOVE protude Avea Code: 13.18 PKTEMPS CONDITION RELATED TO 4. OTHER INSURED'S POLICY OR GROUP INJAMEN A. EMPLOYMENTY (Current or Provious) D. PRINKRYNED FOR MUCC USE E AUTO ACCOUNT? D. OTHER CLASH D-CHESPHEES NUCC e, regaring pinan nuoquae INSURANCE PLAN WARE OR PROGRAM WARE 4. NOUTANCE PLAN NAME OF PROGRAM NAME IS THERE ANCEHED HEALTH BEHERT PLANT READ MACK OF FORM REFORM COMPLETING A SMANNS SHORFORM. 2. PATIENTS OR AUTHORIZED PERSONS SIGNATURE: Lastration benefits of any medical or other information recessing INSUREDIS OR AUTHORIZED PERSONS SIGNATURE I WENNING payment of medical benefits to the undersigned physician or supplier for its grocess five darw. I also request payment of government condition their to myself or to the party who accepts as agreement CHINE I HAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) G CUTHICH LARD **BCHARGES** YES NO 22 P\$40.85000 CRU THE NAME AND POST OF 23, PRIOR AUTHORIZATION NUMBER hea INCLUDING DEGREES OF CREDENTINGS dicardly that the stutements on this revenue agen, to this tall and are wade a part thereof?)

- 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



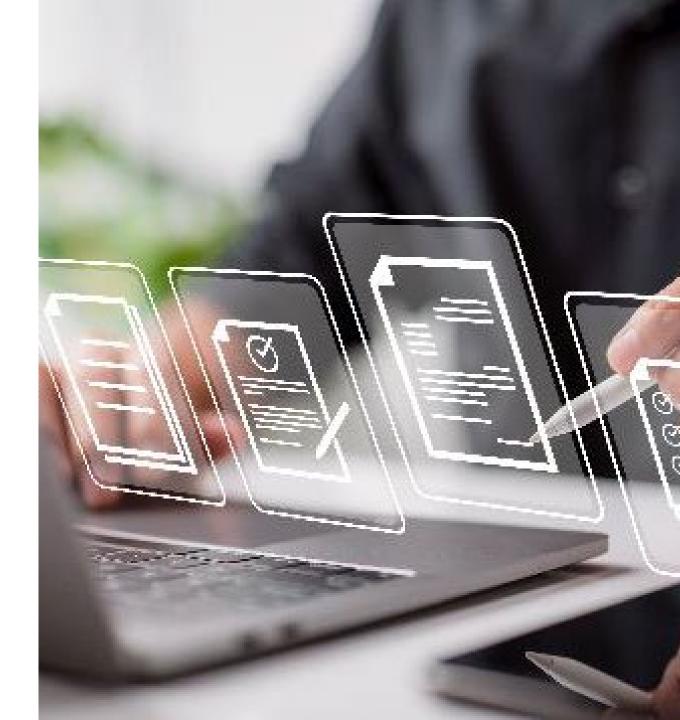


## **EMC Equivalent Line** 23

- 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 APPRIORED BY HATIONAL UNIFORM CLAIM COMMITTEE BLICCLOSIS (Medicanal) (Medicana) (7040)(04) 2. PIXT BARTON NAME (Last Name, First Name, Michiel British LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches S. PATIENT'S ACCPIESS INC., Street DEPARTMENT HILLAND CHARGE TO INSURED INSURED S ADDRESS DV. Steel Set Spruss Over Other STATE & RESERVED FOR MUCC USE TRUMP HORSE BY LINE WAS CORE BLEFFECTURE (Include Avea Code) OTHER INSURED'S POLICY OR GROUP BLAKER A. EMPLOYMENTY (Current or Provious) D. PERSERVED FOR MUCC USE E AURO ACCORDING? D. OTHER CLASH D-CHESPHEES NUCC e regarded non vuocuse 4. MEUDANCE PLAN NAME OF PROCESMINAME IS THERE ANCEHED HEALTH BEHERT PLANT READ MACK OF FORM REFORM COMPLETING A SMANNS SHORFORM. 2. PATIENTS OR AUTHORIZED PERSONS SIGNATURE: Lastration benefits of any medical or other information recessing INSUREDIS OR AUTHORIZED PERSONS SIGNATURE I WENNING premark of medical benefits to the undersigned glysician or sugglier for its groupes five darm. I also required payment of government tonefits either to myself or to the party-who accepts as agreement. I HAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **BCHARGES** YES NO 2 PRIORESTON CRU THE NAME AND POST OF 9. PRIVATE AUTHORIZATION NUMBER INCLUDING DEGREES ON CREDENTIALS dicards that the statements on the revenue apply to this fall and are wade a part thereof:

### Line Items 24A-24J

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





## **EMC Equivalent Lines** 24A-24J

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







#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNPOPMICLAMICOMMETTER SELECTIONS (Medicanal) (Medicana) (7040)(M) 2. PIXT BAYET'S NAME (Last Name, First Name, Mixtell British LENGLIFEET'S NAME CLASSIFIAND, FIRST Name, Mixthe Inches 5. PATIENT'S ACCPIETO INC., SINNO DEPARTMENT HILLAND CHARGE TO INSURED INSURED SADORESS DO STOKE Sign Signus Chip Other STATE 9. RESERVED FOR MUCC USE TREATHCRE Inches Res Code 16.EPHONE DICINIO AVEA CORO. 3. OTHER INSURED/S NAME 6 set Name . First Name . Modific Initials 4. OTHER INSURED'S POLICY OR GROUP BURGER A. EMPLOYMENTY (Current or Provious) D. PRINKRYNED FOR MUCC USE. E AUTO ACCORDITY D. OFHER CLAMID (Designated by NUCC) e regenves non nuccuse CONTRACCOSTANT? I NEURANCE PLAN NAME OF PROGRAM NAME 180 4. MOUTANCE PLAN NAME OF PROGRAM NAME C. IS THERE ANOTHER INEXLTH BENEFIT PLANT 100 CLAM CODES (Designated by NUCC) 190 Byes, complete terms 9, 9s, and 90 BEAD BACK OF FORM REFORM COUPLETING A BRANDS BIRD FORM. 12. PKT ENT'S OF AUTHORICED PETGODYS SIGNATURE: Lautholde the release of any medical or other information recessing. I PASLIFIED S OR ALTHORIZED PERSONS SIGNATURE I WHINKIN premart of medical benefits to the undersigned physician or supplier for its process this dark. I also request payment of government to metals when to messif or to the party-who accepts as agreement CHINE 7 HAME OF REFERENCE PROVIDER ON OTHER SOUNCE FROM 173 191 19 ADDITIONAL CLAIM INFOFMATION CHISQUISES to NUCC O CUTHICIPLARD YES NO CZ PRIOREGISTO CPERNAL REP. NO. INTERNAL MOTOR ZWITCOM NAVABILITY CHOHODE **PICHOCHNO** 25, FEDERAL TAX LD. NUMBER SSN EIN nea () contry that the statements on the revenue apply to the fell and are wade a part thereof ()

### 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
					_
	Federal Tax ID number		REF02	Billing Provider Tax ID	
25	SSN Indicator	2010AA	REF01	Social Security number	Enter the provider of service Federal Tax ID/EIN (EI) or SSN (SY) of the billing provider/group.
	EIN Indicator		REF01	Employer's ID number	



- 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.





EALTH INSURANCE CLAIM FORM			
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#### HEALTH INSURANCE CLAIM FORM APPRIORED BY HACIONAL UNIFORM CLAM COMMITTEE MACCINERS (Midrana) (Midrana) (7040)04) LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches 5. PATIENT'S ACCOMESS INC., Street PATISHT HILATICKSHIP TO REALPSC INSURED S ADDRESS DO STOKE Sign Signatura Chica Chiar STATE 9. RESERVED FOR MUCO USE TRILLIP HORSE BY CHIEF Residence Commit IP COLE IS APPROPRIE DECINOS ANDA COMO 13.18 PKTEMPS CONDITION RELATED TO 4. OTHER INSURED'S POLICY OR GROUP INJAMEN A. EMPLOYMENTY (Current or Provious) D. PRINKRYNED FOR MUCC USE E AURO ACCORDING? D. OTHER CLASH D-CHESPHEES NUCC e, regaring pinan nuoquae OTHER ACCIDENTS INSURANCE PLAN WARE OR PROGRAM WARE YED 4. NOUTANCE PLAN NAME OF PROGRAM NAME OC CLAW CODES (Designated to NUCC) IS THERE ANCEHED HEALTH BEHERT PLANT 190 Byes, compate tens 9, 9s, and 9c BEAD BACK OF FORM REFORM COUPLETING A BRANDS BIRD FORM. 12. PKT ENT'S OF AUTHORICED PETGODYS SIGNATURE: Lautholde the release of any medical or other information recessing. INSUREDIS OR AUTHORIZED PERSONS SIGNATURE I WENNING premark of medical benefits to the undersigned glysician or sugglier for to process this date. I also request payment of government tonefits either to myself or to the party who accepts assignment. CHINE I HAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFORMATION CRegnated to 19200 G CUTHICH LARD **BCHARGES** YES NO 2 PRIORESTON CRU CPESSAL REP. NO. PRIOR AUTHORIZATION NUMBER ROYCONNO SS Revalidy NUCCUM INCLUDING DEGREES OF CREDENTINGS dicards that the statements on the reverse agen, to this tall and are wade a part thereof?)

- 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	CUN07	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.





EALTH INSURANCE CLAIM FOR		
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### HEALTH INSURANCE CLAIM FORM APPRIORED BY HATIONAL UNIFORM CLAM COMMITTEE MACC 0010 (Midrana) (Midrana) (7040)04) LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches S. PATIENT'S ACCPIESS INC., Street S PATIENT RELATIONSHIP TO RESURSO INSURED S ADDRESS DV. Steel Set Spruss Over Other STATE 9. RESERVED FOR MJOC USE TRUMP HORSE BY LINE WAS CORE IS.EPPHORE DIstricts Avea Codes 4. OTHER INSURED'S POLICY OR GROUP NUMBER A. EMPLOYMENTS (Current or Provious) D. PRINKRYNED FOR MUCC USE E AUTO ACCOUNT? D. OFHER CLAMID (Designated by NUCC) e, regaring pinan nuoquae NEURANCE PLANTINGS OF PROGRAM WAS 4. NOUTANCE PLAN NAME OF PROGRAM NAME IS THERE ANCEHED HEALTH BEHERT PLANT 190 Byes, complete terms 9, 9s, and 90 BEAD BACK OF FORM REFORE COMPLETING A BIDANIS BIDEFORM. 2. PATERITS OF AUTHORISED PERSONS SIGNATURE I Authors to ensure of any metod or other information recessively. INSUREDIS OR AUTHORIZED PERSONS SIGNATURE I WENNING premark of medical benefits to the undersigned glysician or sugglier for its groupes five darm. I also required payment of government tonefits either to myself or to the party-who accepts as agreement. I HAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFORMATION CRegnated to 19200 O CUTRICIPLAR **BCHARGES** YES NO 2 PRIORESTON CRU CPERSON, PEP. NO. IS PRINCIPALITHORIZATION NUMBER ROYCONNO INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.) SERVICE ENGINEE A COUNTY IN THE SERVICE SERVICES.

- 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





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

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





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### HEALTH INSURANCE CLAIM FORM (Medicanal) (Medicana) (7040)(M) LENSLINEER'S NAME CLASSINGS. First Name, Missing Inches S. PATIENT'S ACCPIESS INC., Street DEPARTMENT HILLAND CHARGE TO INSURED INSURED SADORESS DV. Steel Sign Spruss Chic Other STATE 9. RESERVED FOR MUCO USE TRUMP HORSE BY LINE WAS CORE ISLEPHONE (Include Avea Code) 4. OTHER INSURED'S POLICY OR GROUP INJAMEN A. EMPLOYMENTY (Current or Provious) D. PRINKRYNED FOR MUCC USE E AURO ACCORDING? D. OTHER CLASH D-CHESPHEES NUCC e regarded non vuocuse 4. MEUDANCE PLAN NAME OF PROCESMINAME IS THERE ANOTHER HEALTH BENEAT PLAN? BEAD BACK OF FORM REFORE COMPLETING A BIDANIS BIDEFORM. 2. PATERITS OF AUTHORISED PERSONS SIGNATURE I Authors to ensure of any metod or other information recessively. INSUREDIS OR AUTHORIZED PERSONS SIGNATURE I WHINKIN payment of medical benefits to the undersigned physician or supplier for its grocess five darw. I also risks set psyment of government tonefits either to myself or to be party who accepts assignment CHINE I HAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 191 9 ADDITIONAL CLAIM INFORMATION CRegnated to 19200 OLITRICE LAR **BCHARGES** YES NO 2 PRIORESTON CRU CPESSAL REP. NO. IS PRINCIPALITHORIZATION NUMBER **PONDODNO** PLEMS PROVIDED INFO & PHIP INCLUDING DEGREES OF CREDENTINGS dicardly that the stutements on this revenue opply to this tall and are trade a part thereof;)

### 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

		2310C 2420C**	NM109 (77) NM109 (77)	Laboratory/Facility Primary Identifier	
		2400	PS101	Purchased service provider identifier	
	NPI	24200	NM101	Identification code qualifier =QB	Enter the NPI of the Service Facility. Enter "XX" in the NM108 to indicate the NPI is present in the NM109.
374		NPI	NM108	Identification code=XX	
		l	NM109	Identification code	maicale the NPI is present in the NN 109.
		2300	NM101	Identification code qualifier #QB	]
			NM108	Identification code	]
		2300	NM109	Identification code	
			REF01	Reference Identification qualifier =EW	
			REF02	Mammogram FDA number	





### Line Items 33 and 33a

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
33	Physician's supplier's billing name, address, zip code & phone number	2010AA or 2010AB	NM103 (85)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
			NM104 NM105	Provider first name Provider middle initial	NM101 Entity Identifier=87-Pay-to-provider
			N301 N401	provider address 1 Provider city	NM102 Entity Type code 1 Person 2 Non-Person Entity
			N402 N403 PER04	Provider state Provider ZIP code Provider phone number	Enter the provider or service/supplier's billing name, address, z code and telephone number. Must be a physical address with nine-digit ZIP code.
33a	NPI	2010AA	NM109 (85)	Provider ID	NM101 Entity Identifier code=85-Billing Provider NM101 Entity Identifier code=87-Pay-to-provider Entire the NPI for the Circup Number or for the performing provider of service/supplier who is a member of a group practice Enter "XX" in the NM108 to indicate an NPI is present in the NM109
336	Billing Taxonomy Number	2000A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PXC





EALTH INSURANCE CLAIM FORM		di di
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# 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.

<sup>\*\* =</sup> 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)
	Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card
2			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr. Sr.)	
3	Patient's Birth Date	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD.
	and gender		DMG03	Gender	Date qualifier (DMG01) = D8
	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the <b>insured's</b> name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
4*			NM104	Other insured first name	
			NM105	Other insured middle name	





<sup>\* =</sup> If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.

## 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

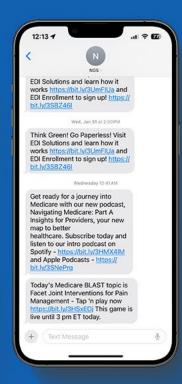


## Questions?

Thank you!







Connect with us on social media





Text NEWS to 37702; Text GAMES to 37702



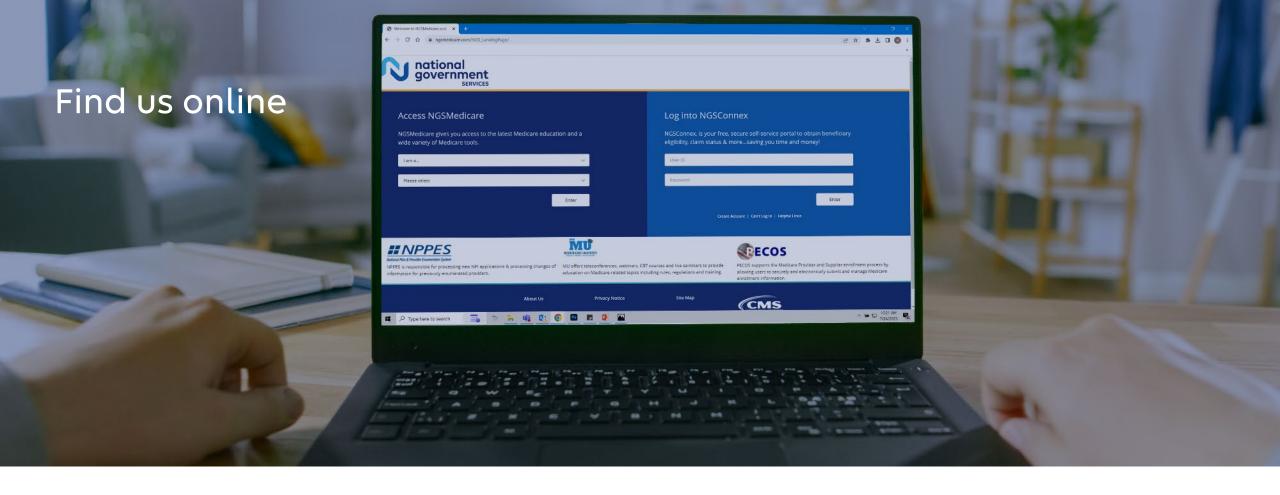
www.MedicareUniversity.com

Self-paced online learning











### www.NGSMedicare.com

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



### IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



### **NGSConnex**

Web portal for claim information



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