

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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Objective

After completion attendees will be able to

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



Agenda

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

Claim Form Requirements

Claim Submission Requirements

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



ASCA Regulations

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

Time Limits for Filing Medicare Claims

Claim Filing Time Limits

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



Claim Form Overview


CMS-1500 Claim Form (02/12)

The diagram shows a CMS-1500 Health Insurance Claim Form with two yellow arrows pointing to specific sections. The first arrow, labeled "Beneficiary data", points to the top section of the form, which includes fields for patient name, address, date of birth, sex, and insurance information. The second arrow, labeled "Provider data", points to the bottom section of the form, which includes fields for provider name, address, and contact information. A red horizontal line is drawn across the middle of the form, separating the beneficiary information from the provider information.



NUCC Approved OMB

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



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

CARRIER

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (DoD/DoD)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (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	
ZIP CODE		TELEPHONE (Include Area Code) () ()		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO	
11. INSURED'S POLICY GROUP OR FECA NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO		b. AUTO ACCIDENT? YES NO		c. OTHER ACCIDENT? YES NO	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? YES NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		22. RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		D. DIAGNOSIS POINTER	
E. \$ CHARGES		F. DAYS OR UNITS		G. H. I. J. RENDERING PROVIDER ID #		K. L. NPI	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? YES NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()		SIGNED		DATE		a. b. #. S.	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

HEALTH INSURANCE CLAIM FORM

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

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

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

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

8. OTHER INSURED'S NAME (Last Name & First Name & Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. CLAIM CODES (Designated by NUCC)

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

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Fields A-L, ICD-9-CM) 22. ICD-9-CM CODE ORIGINAL REP. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (EMR) C. PROVIDER (Physician, Nurse, etc.) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. AMOUNT PAID (ICD-9-CM) G. REVENUE CENTER #

25. FEDERAL TAX ID NUMBER SIGN (IN) 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES/NO) 28. TOTAL CHARGE (\$) 29. AMOUNT PAID (\$) 30. INVOICE NO. (NUCC USE)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH#

Line Item 1

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

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

Line Item 1a

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

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

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

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

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAD TRICARE CHAMPVA GROUP HEALTH PLAN
 (Medicare) (Medicaid) (TRICARE) (Member ID) (Group Health Plan ID)

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

3. PATIENT'S SEX M F

4. PATIENT'S BIRTH DATE MM DD YY

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

6. PATIENT RELATIONSHIP TO INSURED
 Self 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. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT (Current or Previous) YES NO
 b. ALSO ACCIDENT? YES NO PLACE (State) _____
 c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY OR GROUP OR FECA NUMBER

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

13. OTHER CLAIM ID (Designated by NUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO If yes, complete items 16, 17, and 18

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITAL/CLINIC DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB YES NO

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

22. ICD-9-CM CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE OR SUPPLIER (Specify Unusual Circumstances) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

25. FEDERAL TAX ID NUMBER SSN GN

26. PATIENT'S ACCOUNT NO.

27. ACCENT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. FILED BY NUCC/UM

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If certifying that the standards of this covering apply to the bill and on train a part thereof)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

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. and Street)

4. CITY STATE

5. RESERVED FOR NUCC USE

6. EMPLOYMENT (Current or Previous)

7. INSURED'S POLICY OR GROUP NUMBER

8. INSURED'S DATE OF BIRTH

9. OTHER CLAIMED (Designated by NUCC)

10. INSURANCE PLAN NAME OR PROGRAM NAME

11. IS THERE ANOTHER HEALTH BENEFIT PLAN?

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S CARE

15. OTHER DATE

16. DATE (P) DATE (M) DATE (Y) (WORK IN CURRENT OCCUPATION)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. HEMORRHAGE CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER (Organ, Unassisted, or Prosthetic) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. DATE OF SERVICE G. AMOUNT PAID H. RECEIVED #

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. SIGNATURE OF PHYSICIAN OR SUPPLIER

31. SERVICE FACILITY LOCATION INFORMATION

32. 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/VA GLEAD HEALTH PLAN SECA BOX (LMB) OTHER 1% 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. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 7. RESERVED FOR NUCC USE 8. OFFICE CITY STATE ZIP CODE TELEPHONE (Include Area Code)

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) 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 ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE 16. DATE PATIENT BECAME EMPLOYED IN CURRENT OCCUPATION

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL essential line items - ICD-9-CM) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SUPPLY OR SUPPLIER (Diagnose Unusual Circumstances) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. CHARGE G. DATE OF SERVICE H. AMOUNT PAID I. ID. CLM. J. PROVIDING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials to certify that the statements on this statement apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# ()

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Champion of Veterans Affairs) GROUP HEALTH PLAN (Group Health Plan) DEOR (Other) OTHER (Other) % INSURED'S I.D. 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 ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)

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

6. RESERVED FOR NUCC USE

7. INSURANCE PLAN NAME OR PROGRAM NAME

8. 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 other to myself or to the party who accepts assigned below.

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

10. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify AC or external below) ICD-9-CM

12. A. DATE OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER (Specify Unusual Circumstances) D. DIAGNOSIS HONORAR E. CHARGES F. DATE OF BILL G. HONORARY H. ID. QUAL. I. PROVIDING PROVIDER ID #

13. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (Only if the claimant or his/her agent apply to this bill and set it with a post office)

14. SERVICE FACILITY LOCATION INFORMATION

15. 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 (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GEOP/ HEALTH PLAN SECA (U.S. ARMY) OTHER
 (Medicare) (Medicaid) (TRICARE) (Champion) (U.S. Army) (Other)

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

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

4. INSURER'S NAME (Last Name, First Name, Middle Initial) 7. INSURER'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()

10. CLAIM CODES (See guide by NUCC)

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (I, II, III, IV, V, VI, VII, VIII, IX, X, XI, XII, XIII, XIV, XV, XVI, XVII, XVIII, XIX, XX, XXI, XXII, XXIII, XXIV, XXV, XXVI, XXVII, XXVIII, XXIX, XXX) 18. HOUR TO DATE DATES RELATED TO CURRENT SERVICES (FROM, TO) (MM, DD, YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ICD-9-CM code on line below) (A, B, C, D, E, F, G, H, I, J, K, L)

22. PHARMACON CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From, To) (MM, DD, YY) B. PLACE OF SERVICE (I, II, III, IV, V, VI, VII, VIII, IX, X, XI, XII, XIII, XIV, XV, XVI, XVII, XVIII, XIX, XX, XXI, XXII, XXIII, XXIV, XXV, XXVI, XXVII, XXVIII, XXIX, XXX) C. PROCEDURE, SERVICE, OR SUPPLIER (Diagnoses, Unlisted Procedures, Modifiers) D. DIAGNOSIS POSITION E. CHARGE F. CHARGE G. UNIT OR RATE H. UNIT OR RATE I. ID. QUAL. J. RECEIVING 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. PAYER MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (I certify that the statements on this invoice apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PRN# ()

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SEVERE ILLNESS OTHER % INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)

5. PATIENT'S POLICY OR GROUP NUMBER

6. PATIENT RELATIONSHIP TO INSURED
 Self Spouse Child Other

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

8. OTHER INSURED'S POLICY OR GROUP NUMBER

9. RESERVED FOR NUCC USE

10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous)?
 YES NO

11. INSURED'S POLICY OR GROUP OR POLA NUMBER

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

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

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

15. OTHER DATE

16. DATE OF BIRTH (MM DD YY)

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 (Please AC to verbatim below ICD-9-CM)

22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CATEGORIES OF SERVICE FROM TO PLACE OF SERVICE EMS B. DIAGNOSIS HONORAR C. CHARGES D. DATE OF SERVICE E. AMOUNT PAID F. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN ID#

26. PATIENT'S ACCOUNT NO

27. ACCOUNT ASSIGNMENT? (YES NO)

28. TOTAL CHARGE

29. AMOUNT PAID

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (Only if the claimant or his/her agent apply to this SE and set it with a post office)

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PAY #

Line Item 6

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

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

Line Item 7

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER RCV (LIFE) OTHER
 Medicare Medicaid Tricare Medicare Other Other Other

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED (Self 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 (a) EMPLOYMENT (Current or Previous) (b) AUTO ACCIDENT? (c) OTHER ACCIDENT? (d) CLAIM CODES (Designated by NUCC)
 10. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) (If yes, complete items 9, 10, and 11)
 11. 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 to myself or to the party who accepts assignment below.) SIGNED DATE
 12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.) SIGNED DATE
 13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL. 14. OTHER DATE (MM DD YY) QUAL. 15. DATE OF BIRTH (MM DD YY) 16. DATE OF BIRTH (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (M.D. D.O. N.P. N.M.D. N.M.A.) 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 (Provide ALL on reverse side below) (ICD-9-CM) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER
 24. A. DATE(S) OF SERVICE (From To) B. PLACE OF SERVICE (C. PROCEDURE, SERVICE, OR SUPPLY (D. DIAGNOSIS (E. PORTION) F. CHARGES G. DAYS OF SERVICE H. AMOUNT PAID I. CLAIM NO. J. PROVIDING PROVIDER ID #
 25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCENT ASSIGNMENT? (YES/NO) 28. TOTAL CHARGE (A) 29. AMOUNT PAID (B) 30. RESUBMIT FOR NUCC USE
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDE DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are true & not false)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

1. MEDICARE <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (D/M/D/M/D)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No. Street)		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S DATE OF BIRTH MM DD YY		12. OTHER CLAIMS (Designated by NUCC)	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM MM DD YY		15. OTHER DATE MM DD YY		16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAMP <input type="checkbox"/> YES <input type="checkbox"/> NO	
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. SIGNATURE OF PHYSICIAN OR SUPPLIER		30. SERVICE FACILITY LOCATION INFORMATION		31. BILLING PROVIDER INFO & PAF #		32. BILLING PROVIDER INFO & PAF #	

Line Item 8

- Reserved for future NUCC use
- Not mapped electronically

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	2330A	NM103	Other insured last name	Name of insured for Medigap plan
	Name (Last, First,		NM104	Other insured first name	
	Middle Initial)		NM105	Other insured middle name	
9a*	Other insured's policy or group number (Medigap only)	2330A	NM106	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
			NM107	Other insured identifier	Medigap: P Primary S Secondary T Tertiary
		2320	SR031	Payer responsibility	Enter the insured's group or plan number
			SR033	Insured group or policy number	
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	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 36402 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GOVT HEALTH PLAN DECA (DC) (L) (S) OTHER 1a. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last name, first name, middle initial) 2a. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F) 4. INSURED'S NAME (Last name, first name, middle initial)

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE OFF STATE

9. OTHER INSURED'S NAME (Last name, first name, middle initial) 9. RESERVED FOR NUCC USE INSURED'S POLICY GROUP OR FECA NUMBER

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO

11. 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.) WITNESSED DATE SIGNED

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 this to the party who accepts assignment below.) WITNESSED DATE SIGNED

13. DATE OF CLAIM (Month, Day, Year) 14. OTHER DATE (Month, Day, Year) 15. OTHER DATE (Month, Day, Year)

16. DATE OF SERVICE (From To) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Title) 18. HOSPITAL/CLINIC/DATE RELATED TO CURRENT SERVICES (From To)

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

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

24. A. DATE OF SERVICE (From To) B. PLACE OF SERVICE C. ICD-9-CM CODE D. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM, CPT, HCPCS, MODIFIER) E. DIAGNOSIS F. CHARGE G. DATE OF SERVICE H. ICD-9-CM CODE I. REFERRING PROVIDER ID #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Includes description of circumstances if any that the statement or its contents apply to this bill and are in a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ()

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) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER (LIFE) OTHER
 Medicare Medicaid TRICARE Member ID# (ID#) (ID#) (ID#) (ID#)

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

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

CITY STATE ZIP CODE TELEPHONE (3rd or Area Code) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 10. IS PRESENT CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 11. INSURED'S POLICY OR GROUP OR FCDA NUMBER 12. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F) 13. OTHER CLAIMS (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THIS HEALTH BENEFIT PLAN? (Yes, Complete Items 16, 17, and 18) 16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM, DD, YY) QUAL. 17. OTHER DATE (MM, DD, YY) QUAL. 18. DATE OF WORK IN CURRENT OCCUPATION (MM, DD, YY) FROM TO 19. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) 20. HOURS/LOCATION DATES RELATED TO CURRENT SERVICES (MM, DD, YY) FROM TO 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 22. OUTSIDE LAB? (Yes/No) 23. PHYSICIAN CODE ORIGINAL REF. NO. 24. PRIOR AUTHORIZATION NUMBER

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials to certify that the statements of this provider apply to this bill and are made a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# ()

10d. CLAIM CODES (Designated by NUCC)

LINE	DATE OF SERVICE (From MM, DD, YY To MM, DD, YY)	PLACE OF SERVICE (ICD-9-CM)	PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM)	DIAGNOSIS (ICD-9-CM)	CHARGE \$	DATE OF BILL (MM, DD, YY)	AMOUNT PAID \$	ICD-9-CM QUAL.	PROVIDING PROVIDER ID #
1								NP1	
2								NP1	
3								NP1	
4								NP1	
5								NP1	
6								NP1	

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

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

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

CITY STATE ZIP CODE TELEPHONE (3rd or Area Code) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO OTHER INSURED'S POLICY OR GROUP NUMBER

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

11b. OTHER CLAIM ID (Designated by NUCC)

11c. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 14. OTHER DATE QUAL MM DD YY 15. OTHER DATE QUAL MM DD YY

16. DATE OF LAST WORK OCCUPATION FROM TO MM DD YY 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY

18. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAMP \$ CHARGES YES NO 21. PHYSICIAN CODE ORIGINAL REF NO

22. PRIOR AUTHORIZATION NUMBER

23. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER (Explain Unusual Circumstances) D. DIAGNOSIS HONORAR \$ CHARGES DATE OF BILL IN AMOUNT PAID ID QUAL PROVIDING PROVIDER ID #

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

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

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

1. MEDICARE MEDIGAP TRICARE CHAMPVA GROUP HEALTH PLAN DEOR (LIFE) OTHER 1% INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2.1 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 9. RESERVED FOR NUCC USE 10. IS THIS CLAIM RELATED TO: (YES/NO) 11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. ZIP CODE TELEPHONE (3-DIGIT AREA CODE) 13. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F) 14. OTHER CLAIMS (Designated by NUCC)

15. INSURANCE PLAN NAME OR PROGRAM NAME 16. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO)

17. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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 CLAIM (MM, DD, YY) 15. OTHER DATE (MM, DD, YY) 16. DATE OF BIRTH (MM, DD, YY) WORK REQUIREMENT OCCUPATION (FROM, TO)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a, 17b, NP) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAMP (YES/NO) 21. CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to vertical line below ICD-9-CM) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE (From, To, PLACE OF SERVICE, EMS) B. PROVIDER, SERVICE, OR SUPPLIER (Diagnose, Unusual Circumstances, MEDICARE) C. DIAGNOSIS (ICD-9-CM) D. CHARGES (I, II, III, IV, V, VI, VII, VIII, IX, X, XI, XII, XIII, XIV, XV, XVI, XVII, XVIII, XIX, XX, XXI, XXII, XXIII, XXIV, XXV, XXVI, XXVII, XXVIII, XXIX, XXX)

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ASSIGNMENT TO PROVIDER (YES/NO) 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVED FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (certify that the diagnosis or the charges apply to this bill and set it with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Item 13

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

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

Line Item 14

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 30-000 0012

PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SECA (LUMP) OTHER

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. 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 (include Area Code)

7. OTHER INSURED'S NAME (Last name, first name, middle initial)

8. OTHER INSURED'S POLICY OR GROUP NUMBER

9. EMPLOYMENT (Current or Previous) YES NO

10. AUTO ACCIDENT? YES NO

11. OTHER ACCIDENT? YES NO

12. CLAIM CODES (Designated by NUCC)

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

14. DATE OF SERVICE (MM DD YY) FROM TO

15. HOUR OF SERVICE (MM DD YY) FROM TO

16. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Fields A-L to be checked below) A B C D E F G H I J K L

18. PHYSICIAN 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 after I report it to the party who accepts assignment below.) SIGNED

19. DATE OF SERVICE (MM DD YY) FROM TO

20. HOUR OF SERVICE (MM DD YY) FROM TO

21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

22. FEDERAL TAX ID NUMBER SSN EIN

23. PATIENT'S ACCOUNT NO

24. COINSURANCE ASSIGNMENT? YES NO

25. TOTAL CHARGE \$

26. AMOUNT PAID \$

27. 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)

28. SERVICE FACILITY LOCATION INFORMATION

29. BILLING PROVIDER INFO & PH# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

1. MEDICARE <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (DADUCO) <input type="checkbox"/> (Member ID) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (Self or Spouse) <input type="checkbox"/> (Other)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S BIRTH DATE MM DD YY		6. INSURED'S SEX M F	
7. PATIENT'S ADDRESS (No. Street)		8. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		9. RESERVED FOR NUCC USE		10. INSURED'S ADDRESS (No. Street)		11. INSURED'S CITY		12. INSURED'S STATE	
13. CITY		14. STATE		15. ZIP CODE		16. TELEPHONE (3-dig Area Code)		17. CITY		18. STATE	
19. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		20. IS PATIENT'S CONDITION RELATED TO		21. INSURED'S POLICY OR GROUP OR PROGRAM NUMBER		22. INSURED'S DATE OF BIRTH MM DD YY		23. INSURED'S SEX M F		24. OTHER CLAIMS (previously by NUCC)	
25. OTHER INSURED'S POLICY OR GROUP NUMBER		26. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		27. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE (State)		29. OTHER CLAIMS (previously by NUCC)		30. INSURANCE PLAN NAME OR PROGRAM NAME	
31. RESERVED FOR NUCC USE		32. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		33. CLAIM CODES (Designated by NUCC)		34. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		35. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		36. DATE	
37. RESERVED FOR NUCC USE		38. CLAIM CODES (Designated by NUCC)		39. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		40. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		41. DATE		42. SIGNED	
43. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		44. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S QUALIFICATION MM DD YY		45. NAME OF REFERRING PROVIDER OR OTHER SOURCE		46. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		47. ADDITIONAL DATES RELATED TO CURRENT SERVICES MM DD YY		48. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
49. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		50. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to verbalize below ICD-9-CM)		51. PHYSICIAN CODE ORIGINAL REF. NO.		52. PRIOR AUTHORIZATION NUMBER		53. A. CATEGORY OF SERVICE From To PLACE OF SERVICE		54. B. PROVIDER, SERVICES, OR SUPPLIER (Specify Unusual Circumstances)	
55. FEDERAL TAX ID NUMBER		56. PATIENT'S ACCOUNT NO.		57. SERVICE ASSIGNMENT? (To be checked on bill)		58. TOTAL CHARGE		59. AMOUNT PAID		60. RESERVED FOR NUCC USE	
61. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if both that the claimant or his/her agent apply to this bill and set it with a post office)		62. SERVICE FACILITY LOCATION INFORMATION		63. BILLING PROVIDER INFO & PAF ()		64. FEDERAL TAX ID NUMBER		65. PATIENT'S ACCOUNT NO.		66. SERVICE ASSIGNMENT? (To be checked on bill)	

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 (NUCC) 0012

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GOVERNMENT HEALTH PLAN SECA (SEMI-MILITARY) OTHER
 (Medicare) (Medicaid) (TRICARE) (Champion) (Govt Health Plan) (SECA) (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 (include Area Code)
 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 10. IS PHYSICIAN'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Date of Prevalence) YES NO
 b. AUTO ACCIDENT? PLACE (State) YES NO
 c. OTHER ACCIDENT? YES NO
 11. INSURED'S POLICY GROUP OR FECA NUMBER
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than those to the party who accepts assignment below.)
 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete items 14, 15, and 16.)
 14. DATE OF CLAIMED INJURY, ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) QUAL. DATE (MM/DD/YY)
 15. OTHER DATE (MM/DD/YY) QUAL. DATE (MM/DD/YY)
 16. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN, NP)
 17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 18. OUTSIDE LAMP (YES/NO) B-CHARGE#
 19. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes for the claim) (ICD-9-CM)
 A. B. C. D. E. F. G. H. I. J. K. L.
 20. PHYSICIAN OR SUPPLIER IDENTIFICATION CODE (ICD-9-CM) OR SIGNAL REF. NO.
 21. PRIOR AUTHORIZATION NUMBER
 22. FEDERAL TAX ID NUMBER (SSN) SGN SGN
 23. PATIENT'S ACCOUNT NO. 24. ACCOUNT ASSIGNMENT? (YES/NO)
 25. TOTAL CHARGE (\$) 26. AMOUNT PAID (\$) 27. REVENUE (MCO USE)
 28. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials & certify that the statements on this form apply to this bill and are made a part thereof)
 29. SERVICE FACILITY LOCATION INFORMATION
 30. BILLING PROVIDER INFO & PH# ()

1. MEDICARE (Medicare) (Medicaid) (CHIP) (Other)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE (MM, DD, YY)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No. Street)	8. INSURED'S POLICY OR GROUP OR FICA NUMBER
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous)	11. INSURED'S DATE OF BIRTH (MM, DD, YY)	12. OTHER CLAIMS (Covered by MUOC)
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM	15. OTHER DATE	16. DATE OF START AND DATES TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	17b. NPI	18. PRIOR AUTHORIZATION NUMBER
19. SIGNATURE OF PHYSICIAN OR SUPPLIER	20. SERVICE FACILITY LOCATION INFORMATION	21. BILLING PROVIDER INFO & PAY #	22. FEDERAL TAX ID NUMBER

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 3/4/00 0312

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA (LIFE) OTHER
 (Medicare) (Medicaid) (TRICARE) (Champion) (Group Health Plan) (Deca) (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 9. RESERVED FOR NUCC USE 10. CITY STATE

11. ZIP CODE TELEPHONE (3-Digit Area Code) 12. ZIP CODE TELEPHONE (3-Digit Area Code)

13. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 14. IS PATIENT'S CONDITION RELATED TO 15. INSURED'S POLICY OR GROUP OR FICA NUMBER

16. OTHER INSURED'S POLICY OR GROUP NUMBER 17. EMPLOYMENT (Current or Previous) (YES NO) 18. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

19. RESERVED FOR NUCC USE 20. AUTO ACCIDENT? (PLACE SIGN) (YES NO) 21. OTHER CLAIMS (Other than by NUCC) 22. INSURANCE PLAN NAME OR PROGRAM NAME

23. RESERVED FOR NUCC USE 24. OTHER ACCIDENT? (PLACE SIGN) (YES NO) 25. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) (If yes, complete items 9, 14, and 15)

26. INSURANCE PLAN NAME OR PROGRAM NAME 27. CLAIM CODES (Designated by NUCC) 28. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) (If yes, complete items 9, 14, and 15)

29. 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 other than to myself to the party who accepts assignment below.) 30. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

31. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM DD YY) 32. OTHER DATE (MM DD YY) 33. DATE OF BIRTH (MM DD YY) 34. DATE OF BIRTH (MM DD YY)

35. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MD NP) 36. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY TO MM DD YY)

37. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 38. YES NO

39. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to verbalize below ICD-9-CM) 40. PHYSICIAN CODE ORIGINAL REF. NO. 41. PRIOR AUTHORIZATION NUMBER

42. A. CARRIER OF SERVICE (From To) (MM DD YY TO MM DD YY) B. PLACE OF SERVICE (EMS) C. PROVIDER, SERVICES, OR SUPPLIER (Specify Unusual Circumstances) (MD/DC/PO) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. DATE OF BILL G. INPATIENT RATE H. ID. QUAL. I. PROVIDING PROVIDER ID #

43. FEDERAL TAX ID NUMBER 44. SIGN. QN 45. PATIENT'S ACCOUNT NO. 46. ACCOUNT ASSIGNMENT? (YES NO) 47. TOTAL CHARGE 48. AMOUNT PAID 49. RESERVED FOR NUCC USE

50. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING ADDRESS OR CREDENTIALS (Only if the claimant or his/her agent apply to this bill and set it with a post office)) 51. SERVICE FACILITY LOCATION INFORMATION 52. 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

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Champion of Veterans Affairs) GROUP HEALTH PLAN (Group Health Plan) DEER (DEER) OTHER (Other)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)		7. INSURED'S ADDRESS (No. Street)		
CITY		STATE		CITY		
ZIP CODE		TELEPHONE (3-Digit Area Code)		ZIP CODE		
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY OR GROUP OR FICA NUMBER		
9. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT (Current or Previous) YES NO		4. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F)		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES NO PLACE (State)		5. OTHER CLAIMS (Other than by NUCC)		
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO		6. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10a. CLAIM CODES (Designated by NUCC)		6. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 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.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier or persons designated below.		
SIGNED		DATE		SIGNED		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM, DD, YY)		15. OTHER DATE (MM, DD, YY)		16. DATE OF LAST DATE TO WORK IN CURRENT OCCUPATION (MM, DD, YY)		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		
18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please use ICD-9-CM code)		19. PHYSICIAN CODE		20. PRIOR AUTHORIZATION NUMBER		
21. A. DATE OF SERVICE (From, To) B. PLACE OF SERVICE (EMS, EMO) C. PROVIDER, SERVICE, OR SUPPLIER (Specify unless otherwise indicated) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. DATE OF BILL G. NPI H. ID QUAL I. PROVIDING PROVIDER ID #		22. PHYSICIAN CODE		23. PRIOR AUTHORIZATION NUMBER		
24. A. DATE OF SERVICE (From, To) B. PLACE OF SERVICE (EMS, EMO) C. PROVIDER, SERVICE, OR SUPPLIER (Specify unless otherwise indicated) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. DATE OF BILL G. NPI H. ID QUAL I. PROVIDING PROVIDER ID #		25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.		
27. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address or credentials if bill is to the insurer or the insurer apply to the bill and set it with a post office)		28. SERVICE FACILITY LOCATION INFORMATION		29. 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 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

- 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
20	Outside Lab charges	2400	PS101	Purchased Service Provider ID	Required if there are diagnostic tests subject to the anti-markup payment price limits. 2420B is required when a 2400 PS1 is present. When submitting a PS1, you must also submit the facility info in 2310C or 2420C.
		2400	PS102	Purchased Service charge amount	
		2420B	NM1	Purchase service provider	

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GEHA/ HEALTH PLAN SECA/ BOY (LINS) OTHER
 (Medicare) (Medicaid) (TRICARE) (ChampVA) (Other) (Other) (Other)

2. PATIENT'S NAME (Last name, first name, middle initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
 4. INSURED'S NAME (Last name, first name, middle initial)
 5. PATIENT'S ADDRESS (No. Street) 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 PHYSICIAN'S CONDITION RELATED TO (YES NO)
 10. EMPLOYMENT (Date of Pre-claim) (YES NO) PLACE (State)
 11. INSURED'S POLICY OR GROUP OR FECA NUMBER
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)
 13. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)
 14. DATE OF CLAIM (Month, Day, Year) 15. OTHER DATE (Month, Day, Year)
 16. DATE OF SERVICE (Month, Day, Year) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MD, DO, NP, PA)
 18. HOUR OF SERVICE (Month, Day, Year)
 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 20. OUTSIDE LAB? (YES NO) \$ CHARGES
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL to the extent below) (ICD-10-CM)
 22. PHYSICIAN OR SUPPLIER CODE (ICD-10-PCS)
 23. PRIOR AUTHORIZATION NUMBER
 24. A. DATE OF SERVICE (Month, Day, Year) B. PLACE OF SERVICE (Facility) C. PROCEDURE, SUPPLY OR SERVICE (ICD-10-PCS) D. DIAGNOSIS (ICD-10-CM) E. CHARGES (Amount) F. AMOUNT PAID (Amount)
 25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE (\$) 29. AMOUNT PAID (\$) 30. REFERRING PROVIDER ID #
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials to certify it as the statement or its extension apply to this bill and are made a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PFI# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

1. MEDICARE <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (DADUCO) <input type="checkbox"/> (Member ID)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S BIRTH DATE MM DD YY		6. INSURED'S POLICY OR GROUP OR POLY NUMBER	
3. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)		8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S DATE OF BIRTH MM DD YY	
4. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. IS PATIENT'S CONDITION RELATED TO <input type="checkbox"/> YES <input type="checkbox"/> NO		13. INSURED'S POLICY OR GROUP OR POLY NUMBER		14. INSURED'S DATE OF BIRTH MM DD YY		15. OTHER CLAIMS (Designated by NUCC)		16. INSURANCE PLAN NAME OR PROGRAM NAME	
5. OTHER INSURED'S POLICY OR GROUP NUMBER		17. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		18. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		19. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		20. CLAIM CODES (Designated by NUCC)		21. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
6. RESERVED FOR NUCC USE		22. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I, PATIENT 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.		23. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		24. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		25. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM MM DD YY		26. OTHER DATE MM DD YY	
7. RESERVED FOR NUCC USE		27. NAME OF REFERRING PROVIDER OR OTHER SOURCE		28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		29. OUTSIDE LAB <input type="checkbox"/> YES <input type="checkbox"/> NO		30. PHYSICIAN CODE ORIGINAL REF. NO.		31. PRIOR AUTHORIZATION NUMBER	
8. RESERVED FOR NUCC USE		29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		32. DATE OF SERVICE MM DD YY		33. CHARGE \$		34. AMOUNT PAID \$		35. PROVIDER RECEIPT #	
9. RESERVED FOR NUCC USE		30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		36. ICD-10-CM Ind. _____		37. PHYSICIAN OR SUPPLIER INFORMATION		38. SIGNATURE OF PHYSICIAN OR SUPPLIER		39. SERVICE FACILITY LOCATION INFORMATION	
10. RESERVED FOR NUCC USE		31. FEDERAL TAX ID NUMBER		32. PATIENT'S ACCOUNT NO.		33. CREDIT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		34. TOTAL CHARGE		35. AMOUNT PAID	
11. RESERVED FOR NUCC USE		32. SIGNATURE OF PHYSICIAN OR SUPPLIER		33. SERVICE FACILITY LOCATION INFORMATION		34. BILLING PROVIDER INFO & PAF #		35. BILLING PROVIDER INFO & PAF #		36. BILLING PROVIDER INFO & PAF #	

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) 02/12

PCIA NCA PCA

1. MEDICARE MEDICAID TRICARE CHIP/PA GROUP HEALTH PLAN SELF-EMPLOYED OTHER

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

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

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. CITY STATE

9. RESERVED FOR NUCC USE

10. CITY STATE

11. ZIP CODE TELEPHONE (Include Area Code)

12. ZIP CODE TELEPHONE (Include Area Code)

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

14. IS PATIENT'S CONDITION RELATED TO

15. INSURED'S POLICY OR GROUP OR FCDA NUMBER

16. OTHER INSURED'S POLICY OR GROUP NUMBER

17. EMPLOYMENT (Current or Previous)

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

19. RESERVED FOR NUCC USE

20. AUTO ACCIDENT? PLACE (State)

21. OTHER CLAIM# (Designated by NUCC)

22. INSURANCE PLAN NAME OR PROGRAM NAME

23. OTHER ACCIDENT?

24. IS THERE ANOTHER HEALTH BENEFIT PLAN?

25. CLAIM CODES (Designated by NUCC)

26. IS THERE ANOTHER HEALTH BENEFIT PLAN?

27. 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 to myself or to the party who accepts assignment below.)

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

29. SIGNED DATE

30. SIGNED DATE

31. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Start) (MM/DD/YY) QUAL

32. OTHER DATE (MM/DD/YY) QUAL

33. DATE OF LAST WORK-RELATED OCCUPATION (MM/DD/YY)

34. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

36. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

37. OUTSIDE LAB? CHARGES

38. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Write AL to vertical line below ICD-9-CM)

39. RESUBMISSION CODE ORIGINAL REF. NO.

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. PROCEDURE, SERVICE, OR SUPPLY	D. DIAGNOSIS	E. CHARGES	F. ICD-9-CM	G. PROVIDER
From MM/YY	To MM/YY	ICD-9-CM	ICD-9-CM			
1						
2						
3						
4						
5						
6						

25. FEDERAL TAX ID NUMBER SSN

26. PATIENT'S ACCOUNT NO.

27. ACCENT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. RESERVED FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials if apply to the SE and use title as part below)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PRN#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA OR DVA OTHER % 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 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 (3-digit Area Code) ZIP CODE TELEPHONE (3-digit Area Code)

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

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 15. OTHER DATE 16. DATE OF LAST WORK IN CURRENT OCCUPATION

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to be written below ICD-9-CM) 22. PHYSICIAN OR SUPPLIER IDENTIFICATION NUMBER ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. PHYSICIAN, SERVICE, OR SUPPLIER (Explain Unusual Circumstances) D. CHARGE E. ICD-9-CM F. PROCEDURE G. PRODUCT H. PROVIDER IDENTIFICATION #

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (Only if the claimant or his/her agent apply to this SE and set it with a post office) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAF ()

PHYSICIAN OR SUPPLIER INFORMATION

Line Item 23

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

EMC Equivalent Line 23

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEOR (LIFE) OTHER
 (Medicare) (Medicaid) (TRICARE) (Champion) (Group Health Plan) (Deor) (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. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO 11. INSURED'S POLICY OR GROUP OR FICA NUMBER 12. IS THIS ANOTHER HEALTH BENEFIT PLAN? YES NO 13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits either to myself or to the party who accepts assignment below.) 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM, DD, YY) 15. OTHER DATE (QUAL, MM, DD, YY) 16. DATES OF AND PLACES TO WORK IN CURRENT OCCUPATION (FROM, TO, FROM, TO, FROM, TO) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17A, 17B, 17C) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO, FROM, TO) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE CLAIM CHARGES (YES, NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to verbatim below ICD-9-CM) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. 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 CODE	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 3/4/00 0312

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA (or LINE) OTHER 1% INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2.1 PATIENT'S BIRTH DATE (MM DD YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

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

11. ZIP CODE TELEPHONE (3-digit Area Code) 11. ZIP CODE TELEPHONE (3-digit Area Code)

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

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

5. RESERVED FOR NUCC USE 5. AUTO ACCIDENT? PLACE (State) 6. OTHER CLAIMS (previously by NUCC)

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

4. INSURANCE PLAN NAME OR PROGRAM NAME 10c. CLAIM CODES (Designated by NUCC) 6. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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 CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM DD YY) 15. OTHER DATE (MM DD YY) 16. DATES OF AND PLACES TO WORK IN CURRENT OCCUPATION (FROM TO) (FROM TO)

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAMP 21. CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify A-C to be verbatim below ICD-9-CM) 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) (MM DD YY MM DD YY) B. PLACE OF SERVICE (EMS) C. PROVIDER, SUPPLIER, OR SUPPLIER (Specify Unusual Circumstances) (NPI) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. DATE OF SERVICE (MM DD YY) G. HOSPITAL (NPI) H. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN EIN

26. ACCOUNT NO. 27. CREDIT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE (A) 29. AMOUNT PAID (B) 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) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER (LIFE) OTHER
 Medicare Medicaid TRICARE Medicare

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

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

CITY STATE ZIP CODE TELEPHONE (3rd or Area Code) OFF STATE ZIP CODE TELEPHONE (3rd or Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO PLACE (State)
 c. OTHER ACCIDENT? YES NO
 d. CLAIM CODES (Designated by NUCC)

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

11. INSURED'S POLICY OR GROUP OR FCDA NUMBER
 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)
 13. OTHER CLAIMS (Designated by NUCC)
 14. INSURANCE PLAN NAME OR PROGRAM NAME
 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete items 9, 10, and 11)

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 other to myself or to the party who accepts assignment below.
 SIGNED DATE SIGNED

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. OTHER DATE (MM DD YY)
 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 20. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Last) (MM DD YY) QUAL. 21. OTHER DATE (MM DD YY) QUAL.
 22. HOURS/LOCATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY) (MM DD YY)
 23. OUTSIDE LAB? YES NO # CHARGES
 24. PRIOR AUTHORIZATION NUMBER
 25. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM, CPT, HCPCS, ICD-9-CM, CPT, HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. DAYS OF SERVICE G. AMOUNT PAID H. ID. QUAL. I. PROVIDING 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. PROVIDER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDES ADDRESS OR CREDENTIALS to verify that the statements of this service apply to this claim and are within a part thereof) 32. BILLING PROVIDER INFO & P# ()

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEOR (V/L) OTHER 1% 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 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 (3rd or Area Code) ZIP CODE TELEPHONE (3rd or Area Code)

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

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

15. RESERVED FOR NUCC USE 16. AUTO ACCIDENT? PLACE (State) 17. OTHER CLAIM? (Designated by NUCC)

18. RESERVED FOR NUCC USE 19. OTHER ACCIDENT? 20. INSURANCE PLAN NAME OR PROGRAM NAME

21. INSURANCE PLAN NAME OR PROGRAM NAME 22. CLAIM CODES (Designated by NUCC) 23. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 10, and 11)

24. 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 other to myself or to the party who accepts assignment below. 25. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

26. STATE OF CURRENT RESIDENCE (Include ZIP Code) 27. OTHER DATE QUAL MM DD YY 28. DATE OF AND LABEL TO WORK IN CURRENT OCCUPATION FROM TO QUAL MM DD YY

29. NAME OF REFERRING PROVIDER OR OTHER SOURCE 30. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO QUAL MM DD YY

31. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 32. OUTSIDE LAB? CHARGER YES NO

33. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC Event/line below ICD-9-CM) 34. PHYSICIAN CODE ORIGINAL REF. NO. 35. PRIOR AUTHORIZATION NUMBER

36. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROVIDER, SERVICES, OR SUPPLIER (Specify Unusual Circumstances) D. DIAGNOSIS HONORAR E. CHARGER F. DATE OF BILL G. INJURY DATE H. ICD-9-CM I. PROVIDING PROVIDER ID #

1 2 3 4 5 6

37. FEDERAL TAX ID NUMBER 38. SIGN IN 39. PATIENT'S ACCOUNT 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES NO 40. TOTAL CHARGE 41. AMOUNT PAID 42. RESERVED FOR NUCC USE

43. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (Certify that the diagnosis or the charges apply to this bill and set it with a post office) 44. SERVICE FACILITY LOCATION REFERENCE 45. 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	QUM7	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) 02/12

PCIA NCA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER (LIFE) OTHER

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

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

4. PATIENT'S SEX (M/F)

5. PATIENT'S ADDRESS (No. Street)

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

7. INSURED'S ADDRESS (No. Street)

8. CITY

9. STATE

10. ZIP CODE

11. TELEPHONE (Include Area Code)

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

13. IS PRESENT CONDITION RELATED TO

14. EMPLOYMENT (Current or Previous)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (Designated by NUCC)

18. IS THERE ANOTHER HEALTH BENEFIT PLAN?

19. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE

20. DATE

21. SIGNED

22. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Start/End)

23. OTHER DATE

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

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

26. NAME OF REFERRING PROVIDER OR OTHER SOURCE

27. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

28. OUTSIDE LAB?

29. PHYSICIAN OR AUTHORIZED PERSON'S SIGNATURE

30. DATE OF SERVICE (From/To)

31. PROCEDURE, SERVICE, OR SUPPLY

32. DIAGNOSIS

33. CHARGES

34. DATE OF SERVICE (From/To)

35. PROCEDURE, SERVICE, OR SUPPLY

36. DIAGNOSIS

37. CHARGES

38. SIGNATURE OF PHYSICIAN OR SUPPLIER

39. SERVICE FACILITY LOCATION INFORMATION

40. BILLING PROVIDER INFO & PAY

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Rsvd for NUCC Use

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA (LIFE) OTHER % 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 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 (3-digit Area Code) ZIP CODE TELEPHONE (3-digit Area Code)

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

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

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

19. RESERVED FOR NUCC USE 20. OTHER ACCIDENT? 21. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 10, and 11)

22. INSURED'S OR AUTHORIZED REPRESENTATIVE'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. SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 15. OTHER DATE 16. DATES OF AND NUMBER OF WORK-RELATED OCCUPATIONAL INJURY

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to event date below) ICD-9-CM 22. PHYSICIAN CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROVIDER(S), SERVICE(S), OR SUPPLIER(S) (Explain Unusual Circumstances) D. DIAGNOSIS HONORAR 25. CHARGES 26. DATE OF BILL 27. INVOICE NO. 28. PROVIDING PROVIDER ID #

1 2 3 4 5 6

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. PATIENT'S ACCOUNT NO. 33. SERVICE ASSIGNMENT? YES NO 34. TOTAL CHARGE 35. AMOUNT PAID 36. RESERVED FOR NUCC USE

37. SERVICE FACILITY LOCATION INFORMATION 38. BILLING PROVIDER INFO & PAY ()

SIGNED DATE

Line Item 31

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/4/00 0312

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEOR (VETS) OTHER 1% INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2.1 PATIENT'S BIRTH DATE (MM DD YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

8. CITY STATE 9. RESERVED FOR NUCC USE 10. IS THIS CLAIM RELATED TO 11. INSURED'S POLICY OR GROUP OR FICA NUMBER

12. ZIP CODE TELEPHONE (3-DIGIT AREA CODE) 13. IS THIS EMPLOYMENT (Current or Previous) 14. INSURED'S DATE OF BIRTH (MM DD YY) SEX

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

19. RESERVED FOR NUCC USE 20. OTHER ACCIDENT? 21. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete items 9, 10, and 11)

22. INSURANCE PLAN NAME OR PROGRAM NAME 23. CLAIM CODES (Designated by NUCC) 24. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete items 9, 10, and 11)

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

27. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM DD YY) 28. OTHER DATE (MM DD YY) 29. DATE OF START AND LABEL TO WORK IN CURRENT OCCUPATION (FROM TO MM DD YY)

30. NAME OF REFERRING PROVIDER OR OTHER SOURCE 31. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO MM DD YY)

32. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 33. OUTSIDE LAB? \$ CHARGES

34. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AC to event date below) (ICD-9-CM) 35. PHYSICIAN CODE ORIGINAL REF. NO.

36. A. CATHETER OF SERVICE (From To MM DD YY) B. PLACE OF SERVICE (EMG) C. PHYSICIAN, SERVICE, OR SUPPLIER (Diagnose Unusual Circumstances) (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. DATE OF BILL G. NPI ID QUAL. H. PROVIDING PROVIDER ID #

37. FEDERAL TAX ID NUMBER 38. SIGN 39. SERVICE FACILITY LOCATION INFORMATION 40. TOTAL CHARGE 41. AMOUNT PAID 42. RESERVED FOR NUCC USE

43. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (I certify that the diagnosis or the charges apply to this bill and set it with a post office.) 44. BILLING PROVIDER INFO & PAY ()

Line Items 32 and 32a

- All claims require place of service line item 32
 - Ambulance claims
 - Laboratory or service facility
 - Mammography certification
- Purchased test require both 32 and 32a

32a	NPI	2310C	NM109 (ZZ)	Laboratory/Facility Primary Identifier	Enter the NPI of the Service Facility. Enter "XX" in the NM106 to indicate the NPI is present in the NM108.
		2400C**	NM109 (ZZ)	Purchased service provider Identifier	
		2400	PS101	Purchased service provider Identifier	
		2420U	NM101	Identification code qualifier =00	
			NM106	Identification code=XX	
			NM109	Identification code	
			NM101	Identification code qualifier =0R	
			NM106	Identification code	
			NM109	Identification code	
		REF01	Reference Identification qualifier =6W		
REF02	Mammogram FQA number				

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

The information contained in this crosswalk is for reference purposes only.

* = If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.

** = Use if different than information given at the claim level. 7/6/2012 - KJT 1

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary)
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)
2	Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card
			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr. Sr.)	
3	Patient's Birth Date and gender	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8
			DMG03	Gender	
4*	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	

Claim Rejection Reminders

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

Resources, References and Tools

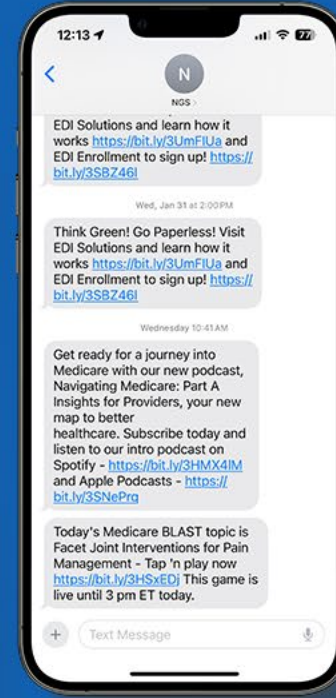
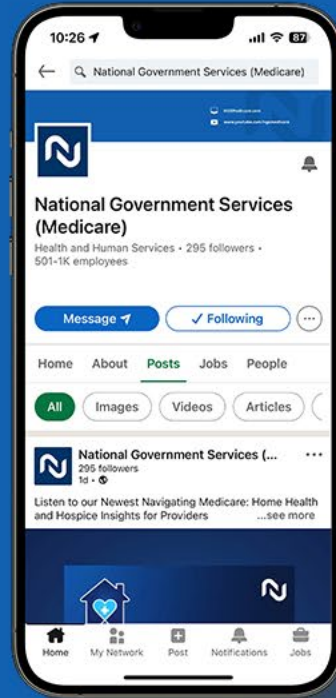
Resources and References

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



Questions?

Thank you!



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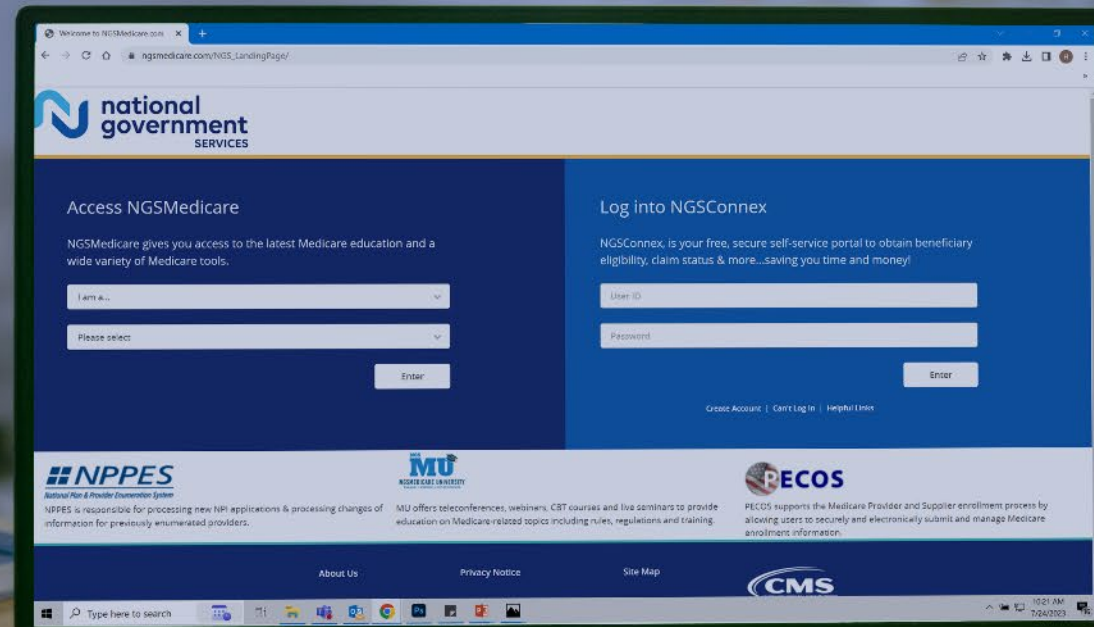
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Educational Content

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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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