

# Proper Part B Claim Submissions

5/28/2025

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# Today's Presenters

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# Recording

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

# Objective

After completion attendees will be able to

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





# Agenda

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

# Claim Form Requirements

# Claim Submission Requirements

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



# ASCA Regulations

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



# Time Limits for Filing Medicare Claims

# Claim Filing Time Limits

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



# Claim Form Overview

# CMS-1500 Claim Form (02/12)

**Beneficiary data** →

**Provider data** →

The form is titled "HEALTH INSURANCE CLAIM FORM" and includes a QR code in the top left corner. It contains various fields for patient information, insurance details, provider information, and billing data. The form is divided into three main sections: "PATIENT AND INSURANCE INFORMATION" (top), "PATIENT AND PROVIDER INFORMATION" (middle), and "PATIENT AND PROVIDER INFORMATION" (bottom). A red horizontal line separates the top section from the middle section. A yellow arrow points from the "Beneficiary data" label to the top section. Another yellow arrow points from the "Provider data" label to the middle section.



# NUCC Approved OMB

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

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

**1. MEDICARE (Medicare #)** **2. MEDICAD (Medicaid #)** **3. TRICARE (TRICARE #)** **4. CHAMPVA (Member ID#)** **5. GROUP HEALTH PLAN (ID#)** **6. FECA (FECA #)** **7. OTHER (ID#)**

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

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

**10. INSURED'S ADDRESS** (No., Street)

**11. INSURED'S CITY** **12. INSURED'S STATE** **13. INSURED'S ZIP CODE** **14. INSURED'S TELEPHONE** (Include Area Code)

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

**16. PATIENT'S BIRTH DATE** **17. PATIENT'S SEX** **18. PATIENT'S RELATIONSHIP TO INSURED** **19. PATIENT'S ADDRESS** (No., Street)

**20. PATIENT'S CITY** **21. PATIENT'S STATE** **22. PATIENT'S ZIP CODE** **23. PATIENT'S TELEPHONE** (Include Area Code)

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

**25. OTHER INSURED'S POLICY OR GROUP NUMBER** **26. EMPLOYMENT** (Current or Previous) **27. AUTO-ACCIDENT** **28. OTHER ACCIDENT**

**29. INSURANCE PLAN NAME OR PROGRAM NAME** **30. IS THERE ANOTHER HEALTH BENEFIT PLAN?**

**31. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** **32. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**

**33. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP)** **34. OTHER DATE** **35. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

**36. NAME OF REFERRING PROVIDER OR OTHER SOURCE** **37. HOSPITALIZATION DATE** **38. OUTSIDE CASE**

**39. ADDITIONAL CLAIM INFORMATION** (Designated by NUCC)

**40. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** **41. REASON FOR CODE** **42. PRIOR AUTHORIZATION NUMBER**

**43. A. DATE(S) OF SERVICE** **44. B. FROM** **45. C. TO** **46. D. PROCEDURE, SERVICE, OR SUPPLY** **47. E. DIAGNOSIS** **48. F. CHARGES** **49. G. DAYS OF SERVICE** **50. H. RATE** **51. I. QUAL** **52. J. RENDERING PROVIDER ID #**

**53. SIGNATURE OF PHYSICIAN OR SUPPLIER** **54. SERVICE FACILITY LOCATION INFORMATION** **55. BILLING PROVIDER INFO & PH #**

**56. SIGNATURE OF PHYSICIAN OR SUPPLIER** **57. DATE** **58. A. SIGNATURE** **59. B. SIGNATURE** **60. C. SIGNATURE** **61. D. SIGNATURE**

NUCC Instruction Manual available at: [www.nucc.org](http://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) 08/12

**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 (incl. Street)**  
 CITY STATE ZIP CODE TELEPHONE (include Area Code)

**6. PATIENT RELATIONSHIP TO INSURED**  
 Self ☐ Spouse ☐ Child ☐ Other ☐

**7. INSURED'S ADDRESS (incl. 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. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)   
 c. OTHER ACCIDENT? ☐ YES ☐ NO  
**11. INSURED'S POLICY 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 below: YES, NO, YES, NO  
**16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  
 SIGNED DATE  
**17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  
 SIGNED  
**18. DATE OF CURRENT SURGERY, INJURY, OR PREGNANCY DATE** MM DD YY **QUAL.**   
**19. NAME OF REFERRING PROVIDER OR OTHER SOURCE** SSN  **20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** FROM MM DD TO MM DD YY  
**21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)**  
**22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** Please AL list in narrative below ICD-9-CM   
 A.  B.  C.  D.   
 E.  F.  G.  H.   
 I.  J.  K.  L.   
**23. A. DATES OF SERVICE** From MM DD YY To MM DD YY **B. PLACE OF SERVICE**  **C. PROVIDER, SUPPLIER, OR SUPPLIER**  **D. PROCEDURE, SERVICE, OR SUPPLY**  **E. DIAGNOSIS**   
**24. A. DATE OF SERVICE** From MM DD YY To MM DD YY **B. PLACE OF SERVICE**  **C. PROVIDER, SUPPLIER, OR SUPPLIER**  **D. PROCEDURE, SERVICE, OR SUPPLY**  **E. DIAGNOSIS**   
**25. FEDERAL TAX ID NUMBER** SSN  **26. PATIENT'S ACCOUNT NO.** **27. ACCEPT ASSIGNMENT?** YES ☐ NO ☐ **28. TOTAL CHARGE** \$  **29. AMOUNT PAID** \$  **30. FEES BY NUCC USE**   
**31. SIGNATURE OF PHYSICIAN OR SUPPLIER** INCLUDING DEGREE OR CREDENTIALS (If both the physician and the provider apply to this SE and are in a self-pay relationship)  
**32. SERVICE FACILITY LOCATION INFORMATION**  
**33. BILLING PROVIDER INFO & Print #** ( )

# 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 MEDICAID TRICARE CHAMPVA SECONDARY HEALTH PLAN (N/A) (Medicare) (Medicaid) (TRICARE) (Champion) (Secondary Health Plan)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S DATE OF BIRTH (MM/DD/YY) 4. PATIENT'S SEX (M/F) 5. PATIENT'S ADDRESS (No. Street) 6. PATIENT'S RELATIONSHIP TO INSURED (Not Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street) 8. INSURED'S CITY 9. INSURED'S STATE 10. INSURED'S ZIP CODE 11. INSURED'S TELEPHONE (Include Area Code) 12. INSURED'S POLICY OR GROUP OR FECA NUMBER 13. INSURED'S DATE OF BIRTH (MM/DD/YY) 14. INSURED'S SEX (M/F) 15. OTHER CLAIM TO DATE (Designated by NUCC) 16. INSURANCE PLAN NAME OR PROGRAM NAME 17. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) 18. 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.) 19. DATE 20. SIGNED

**PHYSICIAN OR SUPPLIER INFORMATION**

21. DATE OF CURRENT ILLNESS, INJURY, OR FREQUENTLY LABORED 22. LENGTH OF TIME (QUAL) 23. NAME OF REFERRING PROVIDER OR OTHER SOURCE 24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO) 25. OUTSIDE LAB? (Yes/No) 26. PHYSICIAN OR SUPPLIER'S SIGNATURE 27. ORIGINAL REF. NO. 28. PRIOR AUTHORIZATION NUMBER

29. A. DATE OF SERVICE (From/To) B. PLACE OF SERVICE (C. PROCEDURE, SERVICE, OR SUPPLY (D. DIAGNOSIS (E. CHARGE) F. DATE OF SERVICE (G. AMOUNT PAID) H. REMARKS (I. PROVIDER'S SIGNATURE (J. SERVICE FACILITY LOCATION INFORMATION (K. BILLING PROVIDER INFO & PH#



**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

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

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

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

4. PATIENT'S ADDRESS (incl. State)

5. CITY STATE ZIP CODE TELEPHONE (include Area Code)

6. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

11. INSURED'S POLICY OR GROUP OR FICA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment 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 to services described below.)

14. DATE OF CURRENT SURVIVAL, INJURY, OR PRESUMPTIVE CLAIM

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please AL list in narrative below ICD-9-CM)

20. PHYSICIAN OR SUPPLIER INFORMATION

21. FEDERAL TAX ID NUMBER

22. PATIENT'S ACCOUNT NO.

23. SERVICE FACILITY LOCATION INFORMATION

24. 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	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8
			DMG03	Gender	

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DISC (LIFE) OTHER 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. PATIENT'S ADDRESS (incl. State)

5. CITY STATE ZIP CODE TELEPHONE (include Area Code)

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

7. OTHER INSURED'S POLICY OR GROUP NUMBER

8. RESERVED FOR NUCC USE

9. RESERVED FOR NUCC USE

10. INSURANCE PLAN NAME OR PROGRAM NAME

11. IS PHYSIAN'S CONDITION RELATED TO

12. EMPLOYMENT (Current or Previous)

13. AUTO ACCIDENT?

14. OTHER ACCIDENT?

15. CLAIM CODES (Designated by NUCC)

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

17. OTHER CLAIM (Designated by NUCC)

18. INSURANCE PLAN NAME OR PROGRAM NAME

19. IS THERE ANOTHER HEALTH BENEFIT PLAN?

20. YES NO (yes, complete items 19, 20, and 21)

21. 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 contribution to be paid to the party who accepts assignment below.)

22. DATE OF CURRENT SURVIVAL SURVIVAL OR PREVIOUSLY LOST

23. OTHER DATE

24. DATE OF LAST SURVIVAL SURVIVAL OR PREVIOUSLY LOST

25. NAME OF REFERRING PROVIDER OR OTHER SOURCE

26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

27. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY (Include all entries for each ICD-9-CM code)

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

29. DATE OF SERVICE FROM TO PLACE OF SERVICE (Indicate Unusual Circumstances)

30. PROCEDURE, SERVICE, OR SUPPLY (Indicate Unusual Circumstances)

31. DIAGNOSIS POSITION

32. P. Q. R. S. T. U. V. W. X. Y. Z.

33. ORIGINAL REF. NO.

34. PRIOR AUTHORIZATION NUMBER

35. FEDERAL TAX ID NUMBER

36. PATIENT'S ACCOUNT NO.

37. ACCOUNT ASSIGNMENT?

38. TOTAL CHARGE

39. AMOUNT PAID

40. RESERVED FOR NUCC USE

41. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that this statement or this request applies to this bill and will be paid a part thereof))

42. SERVICE FACILITY LOCATION INFORMATION

43. BILLING PROVIDER INFO & P# ( )



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

1. MEDICARE MEDICAID TRICARE CHAMPVA SEVERE DISABILITY PLAN OTHER (For Programs in Item 1)

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR MUCC USE

11. RESERVED FOR MUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I, the patient or authorized person's signature, authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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

15. OTHER DATE

16. DATE OF BIRTH AND NUMBER TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

20. OUTSIDE LAMP

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide AC code and date below)

22. PHYSICIAN OR SUPPLIER INFORMATION

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. CREDIT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. RESERVE MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OF OFFICE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ( )

## Line Item 4

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

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



# Line Item 5

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA DEPT. OF VETERANS AFFAIRS (DVA) OTHER (Specify)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. INSURER'S POLICY OR GROUP OR FICA NUMBER

7. INSURER'S DATE OF BIRTH (MM/DD/YY)

8. OTHER CLAIM ID (Designated by NUCC)

9. INSURANCE PLAN NAME OR PROGRAM NAME

10. CLAIM CODES (Designated by NUCC)

11. 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 due to me or to the party who accepts assignment herein.)

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

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

15. OTHER DATE (MM/DD/YY)

16. DATE PATIENT CAME TO WORK (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. OUTSIDE LAB? (YES/NO)

20. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify all, in words below ICD-9-CM)

22. PHYSICIAN OR SUPPLIER (Specify Unusual Circumstances)

23. PHYSICIAN OR SUPPLIER (Specify Unusual Circumstances)

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

25. FEDERAL TAX ID NUMBER (SSAN) 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT (YES/NO) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REMAINING BALANCE \$

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 & P# ( )

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER 1% INSURED'S ID 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 (Include Area Code)

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

6. OTHER INSURED'S POLICY OR GROUP NUMBER

7. RESERVED FOR MUCC USE

8. RESERVED FOR MUCC USE

9. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. INSURED'S DATE OF BIRTH SEX

13. OTHER CLAIMS (Designated by MUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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 assigned claims.)

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

18. DATE OF CURRENT ILLNESS, INJURY, OR PREEXISTING CLAIM

19. OTHER DATE

20. DATE WHEN PATIENT WOULD RETURN TO WORK IN CURRENT OCCUPATION

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE

22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

23. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

24. OUTSIDE LAMP

25. PHYSICIAN OR SUPPLIER INFORMATION

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9 code below)

27. PHYSICIAN OR SUPPLIER INFORMATION

28. A. CARRIER OF SERVICE FROM B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

29. FEDERAL TAX ID NUMBER

30. PATIENT'S ACCOUNT NO.

31. CREDIT ASSIGNMENT?

32. TOTAL CHARGE

33. AMOUNT PAID

34. SIGNATURE OF PHYSICIAN OR SUPPLIER

35. SERVICE FACILITY LOCATION INFORMATION

36. 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 OTHER (See Instructions)

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

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

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESUBMITTED FOR NUCC USE

11. RESUBMITTED FOR NUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. IS PATIENT'S CONDITION RELATED TO:

14. EMPLOYMENT (Current or Previous)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (See guide by NUCC)

18. INSURED'S DATE OF BIRTH

19. OTHER CLAIM ID (See guide by NUCC)

20. INSURANCE PLAN NAME OR PROGRAM NAME

21. IS THERE ANOTHER HEALTH BENEFIT PLAN?

22. 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 after to report to the party who accepts assignment below.)

23. DATE

24. DATE OF CURRENT SURVIVAL, INJURY, OR PREVIOUSLY CLAIMED

25. OTHER DATE

26. DATE OF BIRTH

27. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

28. OUTSIDE LAB?

29. PRIOR AUTHORIZATION NUMBER

30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all, even when below 400)

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

32. A. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

33. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

34. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

35. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

36. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

37. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

38. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

39. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

40. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

41. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

42. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

43. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

44. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

45. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

46. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

47. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

48. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

49. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

50. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

51. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

52. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

53. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

54. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

55. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

56. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

57. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

58. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

59. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

60. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

61. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

62. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

63. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

64. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

65. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

66. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

67. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

68. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

69. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

70. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

71. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

72. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

73. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

74. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

75. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

76. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

77. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

78. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

79. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

80. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

81. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

82. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

83. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

84. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

85. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

86. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

87. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

88. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

89. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

90. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

91. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

92. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

93. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

94. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

95. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

96. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

97. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

98. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

99. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

100. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

**CARQUEST**

PATIENT AND INSURED INFORMATION

IN CALYPSO OF THE LITERATURE OF THE 19TH CENTURY

- Reserved for future NUCC use
- Not mapped electronically



# Line Items 9, 9a–9d

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

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

1. MEDICARE MEDIGAP TRICARE CHAMPVA GROUP HEALTH PLAN IS OR NO (LINE 10) OTHER

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

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

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Include Area Code)

17. INSURED'S POLICY OR GROUP OR FICA NUMBER

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

19. INSURED'S SEX (M/F)

20. OTHER CLAIM ID (Date granted by NUCC)

21. INSURANCE PLAN NAME OR PROGRAM NAME

22. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

24. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S CLAIM

25. DATE OF CLAIM

26. DATE OF SERVICE (MM/YY)

27. NAME OF REFERRING PROVIDER OR OTHER SOURCE

28. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

29. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, even if not below ICD-9)

30. PHYSICIAN OR SUPPLIER'S SIGNATURE

31. PHYSICIAN OR SUPPLIER'S ID NUMBER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY #



# EMC Equivalent Lines 9, 9a–9d

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
9*	Other insured's	2330A	NM103	Other insured last name	Name of insured for Medigap plan
	Name (Last, First, Middle Initial)		NM104	Other insured first name	
			NM105	Other insured middle name	
9a*	Other insured's policy or group number (Medigap only)	2330A	NM106	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
			NM109	Other insured identifier	Medigap: P Primary S Secondary T Tertiary
		2320	SR031	Payer responsibility	
			SR033	Insured group or policy number	Enter the insured's group or plan number
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	2330B	N401	Other payer city name	Enter the city, state and ZIP code of the insurer. Required if any other payers are known to potentially be involved in paying this claim.
			N402	Other payer state code	
			N403	Other payer ZIP code	
9d*	Insurance plan name or program name	2330B	NM108	Other payer Identification Code Qualifier	Medigap plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	

# HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA OTHER HEALTH PLAN SELECT (LINE) OTHER

2. PATIENT'S NAME (Last name, first name, middle initial)

3. PATIENT'S ADDRESS (incl. Street)

4. CITY

5. STATE

6. ZIP CODE

7. PATIENT'S RELATIONSHIP TO INSURED

8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

b. AUTO ACCIDENT? PLACE (State)

c. OTHER ACCIDENT?

11. INSURED'S POLICY GROUP OR PROGRAM NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. DATE

14. DATE OF CLARIFIED SURVIVAL, INJURY, OR PREGNANCY CLARIFICATION

15. OTHER DATE

16. DATE OF BIRTH

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include all, to be selective below (ICD-9-CM))

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

21. OUTSIDE LAB

22. PRIOR AUTHORIZATION NUMBER

23. BILLING PROVIDER INFO & Pmt #

24. A. DATES OF SERVICE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. PAYEE'S NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

## 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 OTHER (See Instructions) 1d. 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 (See Instructions) 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RECEIPTED FOR NUCC USE OFF ( ) STATE ( )

ZIP CODE TELEPHONE (Include Area Code) 2P 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 OR GROUP OR FICA NUMBER

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

15. RESUBMITTED FOR NUCC USE 16. AUTO ACCIDENT? ( ) PLACE (State) 17. OTHER CLAIM ID (See Instructions)

18. RESUBMITTED 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. ANOTHER HEALTH BENEFIT PLAN? ( )

24. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (to process this claim, I also request payment of government contribution to input or to the party who accepts assignment below) 25. PHYSICIAN OR SUPPLIER SIGNATURE (to process this claim, I also request payment of government contribution to input or to the party who accepts assignment below)

26. DATE OF CURRENT SURVIVAL, INJURY, OR PREVIOUSLY CLAIMED 27. OTHER DATE 28. DATE OF BIRTH (MM/DD/YY) WORK IN CURRENT OCCUPATION ( )

29. NAME OF REFERRING PROVIDER OR OTHER SOURCE 30. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES ( )

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

33. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all, even inactive below ICD-9-CM) 34. PHYSICIAN OR SUPPLIER SIGNATURE 35. PRIOR AUTHORIZATION NUMBER

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

37. FEDERAL TAX ID NUMBER 38. PATIENT'S ACCOUNT NO. 39. ACCOUNT ASSIGNMENT? ( ) 40. TOTAL CHARGE \$ 41. AMOUNT PAID \$ 42. REMAINING BALANCE \$

43. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials (I certify that this statement or its contents apply to this claim and are made a part thereof)) 44. SERVICE FACILITY LOCATION INFORMATION 45. BILLING PROVIDER INFO & Print ( )



**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

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

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO PREVIOUS CONDITION? 10. IS PRESENT CONDITION RELATED TO PREVIOUS CONDITION?

11. INSURED'S POLICY OR GROUP NUMBER

11a. INSURED'S DATE OF BIRTH MM DD YY SEX 11b. OTHER CLAIM ID (Designated by NUCC) 11c. INSURANCE PLAN NAME OR PROGRAM NAME 11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

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

13. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED QUAL. 14. OTHER DATE MM DD YY 15. DATE OF LAST WORK IN CURRENT OCCUPATION MM DD YY 16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO 17. OUTSIDE LAB? YES NO 18. PHYSICIAN CODE ORIGINAL REF. NO. 19. PRIOR AUTHORIZATION NUMBER

20. A. CATHETER OF SERVICE FROM TO B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unless Otherwise Indicated) E. DIAGNOSIS (ICD-9-CM) F. CHARGE G. CHARGE H. CHARGE I. CHARGE J. NONCOVERING PROVIDER ID #

21. FEDERAL TAX ID NUMBER 22. PATIENT'S ACCOUNT NO. 23. CREDIT ASSIGNMENT? YES NO 24. TOTAL CHARGE 25. AMOUNT PAID 26. PAYEE NUCC USE

27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS I certify that the claims to be submitted apply to this bill and are within a past benefit.

28. SERVICE FACILITY LOCATION INFORMATION 29. BILLING PROVIDER INFO & PAY ( )

# Line Items 11, 11a–11d

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

# EMC Equivalent Line 11, 11a–11c

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
11*	Insured policy group or FECA number	2320 or 2000B	SBR01	Payer responsibility P = Primary S = Secondary T = Tertiary <b>*Note:</b> If Medicare is Primary, use letter "P" and skip to item 12.	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to potentially be involved in paying this claim.
		2320	SBR03	Insured Group or Policy Number	
		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
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2300 or 2430	CN102	OTAF amount	
		2430	SVD01	Identification code	
			SVD02	Primary payer paid amount (line level)	
			SVD03	Medical procedure identifier	
			SVD03-1	Service ID qualifier	
			SVD03-2	Service ID	
			SVD05	Quantity	
		2330B	NM101	Entity identifier code	
			NM102	Entity type code	
			NM103	Last name or organization	
			NM108	Identification code qualifier	
			NM109	Identification code	
11a*	Insured date of birth and sex-				
11b*	Employer's name or school				
11c	Insurance plan name or program name	2320	SBR04	Other Insured Group Name	Enter the complete insurance plan or program name
		2330B	NM103	Other payer organization name	Enter the complete insurance plan name
		2330B	NM109	Other payer primary identifier	Enter the payer ID of the other insurer

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



# Line Item 12

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER  
☐ MEDICAID ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. INSURED'S POLICY OR GROUP OR FICA NUMBER 6. INSURED'S DATE OF BIRTH MM DD YY SEX M F 7. OTHER CLAIM ID (as granted by NUCC) 8. INSURANCE PLAN NAME OR PROGRAM NAME 9. 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.  
SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

13. NAME OF REFERRING PROVIDER OR OTHER SOURCE 14. HOSPITAL/CLINIC DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 15. OUTSIDE LAB? YES NO 16. REFERRAL CODE ORIGINAL REF NO 17. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REMAINING BALANCE \$ 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the signature on this cover applies to the bill and is made in good faith.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ( )

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

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

8. CITY STATE 9. RESIDENT FOR MEDICARE 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 PRESENT CONDITION RELATED TO: 15. INSURED'S POLICY OR GROUP OR FICA NUMBER

16. OTHER INSURED'S POLICY OR GROUP NUMBER 17. EMPLOYMENT (Current or Former) 18. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)

19. RESERVED FOR MEDICARE USE 20. AUTO ACCIDENT? (Place Stamp) 21. OTHER CLAIM ID (Designated by NUGO)

22. RESERVED FOR MEDICARE USE 23. OTHER ACCIDENT? (Place Stamp) 24. INSURANCE PLAN NAME OR PROGRAM NAME 25. IS THERE ANOTHER HEALTH BENEFIT PLAN?

26. CLAIM CODES (Designated by NUGO) 27. IS THERE ANOTHER HEALTH BENEFIT PLAN?

28. READ BACK OF FORM BEFORE SIGNATURE & SIGNING THIS FORM. 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 or government benefits other to myself or to the party who accepts assigned below. SIGNED

30. DATE 31. DATE

32. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S CLAIM 33. OTHER DATE 34. DATE OF BIRTH (MM/DD/YY) 35. DATE OF BIRTH (MM/DD/YY) 36. DATE OF BIRTH (MM/DD/YY)

37. NAME OF REFERRING PROVIDER OR OTHER SOURCE 38. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 39. OUTSIDE LAB? 40. PHYSICIAN CODE 41. ORIGINAL REF. NO.

42. ADDITIONAL CLAIM INFORMATION (Designated by NUGO) 43. PRIOR AUTHORIZATION NUMBER

44. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please use ICD-9-CM code below) 45. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

46. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

47. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

48. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

49. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

50. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

51. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

52. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

53. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

54. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

55. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

56. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

57. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

58. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

59. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

60. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

61. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

62. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

63. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

64. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

65. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

66. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

67. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

68. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

69. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

70. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

71. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

72. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

73. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

74. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

75. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

76. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

77. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

78. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

79. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

80. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

81. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

82. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

83. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

84. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

85. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

86. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

87. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

88. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

89. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

90. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

91. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

92. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

93. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

94. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

95. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

96. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

97. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

98. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

99. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

100. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

## 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



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



HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012											
PCIA <input type="checkbox"/> <input type="checkbox"/>											
<div> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHIP/VA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> OTHER <input type="checkbox"/> </div> <div> 2. PATIENT'S NAME (Last, First, Middle Initial) </div> <div> 3. PATIENT'S ADDRESS (No. &amp; Apt.) </div> <div> 4. CITY </div> <div> 5. STATE </div> <div> 6. ZIP CODE </div> <div> 7. TELEPHONE (Include Area Code) </div> <div> 8. OTHER INSURED'S NAME (Last, First, Middle Initial) </div> <div> 9. OTHER INSURED'S POLICY OR GROUP NUMBER </div> <div> 10. RESERVED FOR NUCC USE </div> <div> 11. RESERVED FOR NUCC USE </div> <div> 12. RESERVED FOR NUCC USE </div> <div> 13. INSURANCE PLAN NAME OR PROGRAM NAME </div> </div>											
<div> <div> 14. PATIENT'S DATE OF BIRTH (MM/DD/YY) </div> <div> 15. PATIENT'S RELATIONSHIP TO INSURED </div> <div> 16. INSURED'S ADDRESS (No. &amp; Apt.) </div> <div> 17. CITY </div> <div> 18. STATE </div> <div> 19. ZIP CODE </div> <div> 20. TELEPHONE (Include Area Code) </div> <div> 21. INSURED'S POLICY OR GROUP NUMBER </div> <div> 22. INSURED'S DATE OF BIRTH (MM/DD/YY) </div> <div> 23. OTHER CLAIM ID (Designated by NUCC) </div> <div> 24. INSURANCE PLAN NAME OR PROGRAM NAME </div> <div> 25. IS THERE ANOTHER HEALTH BENEFIT PLAN? </div> <div> 26. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than to the party who accepts assignment below.) </div> <div> 27. SIGNED </div> </div>											
<div> <div> 28. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) </div> <div> 29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) </div> <div> 30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, or describe below) </div> <div> 31. DATE OF SERVICE </div> <div> 32. PLACE OF SERVICE </div> <div> 33. PROVIDER'S NAME (Last, First, Middle Initial) </div> <div> 34. PROVIDER'S ADDRESS </div> <div> 35. PROVIDER'S PHONE </div> <div> 36. PROVIDER'S FAX </div> <div> 37. PROVIDER'S EMAIL </div> <div> 38. PROVIDER'S LICENSE </div> <div> 39. PROVIDER'S NPI </div> <div> 40. PROVIDER'S TAX ID </div> <div> 41. PROVIDER'S SIGNATURE </div> <div> 42. PROVIDER'S PRINTED NAME </div> <div> 43. PROVIDER'S TITLE </div> <div> 44. PROVIDER'S ORGANIZATION </div> <div> 45. PROVIDER'S ADDRESS </div> <div> 46. PROVIDER'S PHONE </div> <div> 47. PROVIDER'S FAX </div> <div> 48. PROVIDER'S EMAIL </div> <div> 49. PROVIDER'S LICENSE </div> <div> 50. PROVIDER'S NPI </div> <div> 51. 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PROVIDER'S ORGANIZATION </div> <div> 133. PROVIDER'S ADDRESS </div> <div> 134. PROVIDER'S PHONE </div> <div> 135. PROVIDER'S FAX </div> <div> 136. PROVIDER'S EMAIL </div> <div> 137. PROVIDER'S LICENSE </div> <div> 138. PROVIDER'S NPI </div> <div> 139. PROVIDER'S TAX ID </div> <div> 140. PROVIDER'S SIGNATURE </div> <div> 141. PROVIDER'S PRINTED NAME </div> <div> 142. PROVIDER'S TITLE </div> <div> 143. PROVIDER'S ORGANIZATION </div> <div> 144. PROVIDER'S ADDRESS </div> <div> 145. PROVIDER'S PHONE </div> <div> 146. PROVIDER'S FAX </div> <div> 147. PROVIDER'S EMAIL </div> <div> 148. PROVIDER'S LICENSE </div> <div> 149. PROVIDER'S NPI </div> <div> 150. PROVIDER'S TAX ID </div> <div> 151. PROVIDER'S SIGNATURE </div> <div> 152. PROVIDER'S PRINTED NAME </div> <div> 153. PROVIDER'S TITLE </div> <div> 154. PROVIDER'S ORGANIZATION </div> <div> 155. PROVIDER'S ADDRESS </div> <div> 156. PROVIDER'S PHONE </div> <div> 157. PROVIDER'S FAX </div> <div> 158. PROVIDER'S EMAIL </div> <div> 159. 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PROVIDER'S EMAIL </div> <div> 214. PROVIDER'S LICENSE </div> <div> 215. PROVIDER'S NPI </div> <div> 216. PROVIDER'S TAX ID </div> <div> 217. PROVIDER'S SIGNATURE </div> <div> 218. PROVIDER'S PRINTED NAME </div> <div> 219. PROVIDER'S TITLE </div> <div> 220. PROVIDER'S ORGANIZATION </div> <div> 221. PROVIDER'S ADDRESS </div> <div> 222. PROVIDER'S PHONE </div> <div> 223. PROVIDER'S FAX </div> <div> 224. PROVIDER'S EMAIL </div> <div> 225. PROVIDER'S LICENSE </div> <div> 226. PROVIDER'S NPI </div> <div> 227. PROVIDER'S TAX ID </div> <div> 228. PROVIDER'S SIGNATURE </div> <div> 229. PROVIDER'S PRINTED NAME </div> <div> 230. PROVIDER'S TITLE </div></div>											



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 00/01/02

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER RY (LINE) OTHER										14. INSURED'S ID NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX									
5. PATIENT'S ADDRESS (No. Street)										6. PATIENT'S RELATIONSHIP TO INSURED									
CITY										7. INSURED'S ADDRESS (No. Street)									
STATE										8. CITY									
ZIP CODE										9. TELEPHONE (Include Area Code)									
10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR POLICY NUMBER									
12. OTHER INSURED'S POLICY OR GROUP NUMBER										13. INSURED'S DATE OF BIRTH MM DD YY SEX									
14. RESERVED FOR MUCC USE										15. OTHER CLAIM (Designated by MUCC)									
16. RESERVED FOR MUCC USE										17. INSURANCE PLAN NAME OR PROGRAM NAME									
18. INSURANCE PLAN NAME OR PROGRAM NAME										19. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
20. READ BACK OF FORM BEFORE SIGNATURES & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be assigned to the party who accepts assignment below.										21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)									
22. SIGNED										23. SIGNED									
24. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S DATE QUAL. MM DD YY										25. DATE WHEN LAST WORK IN CURRENT OCCUPATION TO MM DD YY									
26. NAME OF REFERRING PROVIDER OR OTHER SOURCE										27. EDUCATION DATES RELATED TO CURRENT SERVICES TO MM DD YY									
28. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)										29. OUTSIDE LAB? \$ CHARGE									
30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide AC code below) A. B. C. D. E. F. G. H. I. J. K. L.										31. PHYSICIAN CODE ORIGINAL REF. NO.									
32. PRIOR AUTHORIZATION NUMBER										33. PHYSICIAN OR SUPPLIER INFORMATION									
34. A. CARRIER OF SERVICE From To B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.										35. PHYSICIAN OR SUPPLIER INFORMATION									
36. FEDERAL TAX ID NUMBER										37. PATIENT'S ACCOUNT NO.									
38. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address or credentials. I certify that the claims to be the correct copy to the SE and are within a part thereof.)										39. SERVICE FACILITY LOCATION INFORMATION									
40. BILLING PROVIDER INFO & PAY ( )										41. BILLING PROVIDER INFO & PAY ( )									

## Line Item 15

- Not required
- Not mapped electronically

# Line Item 16

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

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

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

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

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

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

CITY STATE 8. RESERVED FOR NUCC USE OFF STATE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PHYSICIAN'S CONDITION RELATED TO 11. INSURED'S POLICY OR GROUP OR PEOA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government contribution to input it to the party who accepts assignment below.) 13. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 14. INSURED'S POLICY OR GROUP OR PEOA NUMBER

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) (If yes, complete items 16, 17, and 18.) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19. DATE OF LATEST SURVIVAL REPORT, IF APPLICABLE (MM/DD/YY) 20. OTHER DATE (MM/DD/YY)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all codes for each diagnosis) 22. PHYSICIAN'S SIGNATURE (Original or Photocopy) 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE (Indicate United States/Overseas) C. PROCEDURE, SERVICE, OR SUPPLY (Indicate United States/Overseas) D. DIAGNOSIS (ICD-9-CM) E. CHARGE (ICD-9-CM) F. CHARGE (ICD-9-CM) G. CHARGE (ICD-9-CM) H. CHARGE (ICD-9-CM) I. CHARGE (ICD-9-CM) J. CHARGE (ICD-9-CM) K. CHARGE (ICD-9-CM) L. CHARGE (ICD-9-CM)

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (Yes/No) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REMAINING BALANCE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on this reverse apply to this bill and will be with a paid bill.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# ( )



**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (See Instructions) 14. INSURED'S ID NUMBER (For Programs in Item 1)

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

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

12. OTHER INSURED'S POLICY OR GROUP NUMBER 13. EMPLOYMENT (Current or Former) (See Instructions) 14. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)

15. RESERVED FOR NUCC USE 16. AUTO ACCIDENT? (See Instructions) 17. OTHER CLAIM ID (See Instructions)

18. RESERVED FOR NUCC USE 19. OTHER ACCIDENT? (See Instructions) 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? (See Instructions)

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 or payment credits to be paid 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.)

SIGNED DATE SIGNED

26. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUS CLAIM (MM/DD/YY) 27. OTHER DATE (MM/DD/YY) 28. DATE OF LAST WORK IN CURRENT OCCUPATION (MM/DD/YY)

29. NAME OF REFERRING PROVIDER OR OTHER SOURCE 30. NPI 31. DATES RELATED TO CURRENT SERVICES (MM/DD/YY) (See Instructions)

32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please use ICD-9-CM code for diagnosis) 33. PHYSICIAN OR SUPPLIER INFORMATION (See Instructions)

34. A. CARRIER OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) B. CARRIER OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) C. PROCEDURE, SERVICE, OR SUPPLY (See Instructions) D. DATE OF SERVICE (MM/DD/YY) E. CHARGE (See Instructions) F. PRIOR AUTHORIZATION NUMBER

35. MEDICAL TAX ID NUMBER 36. PATIENT'S ACCOUNT NO. 37. CREDIT ASSIGNMENT? (YES/NO) 38. TOTAL CHARGE 39. AMOUNT PAID 40. RESERVED FOR NUCC USE

41. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the information on this claim applies to the bill and not to a past service.) 42. SERVICE FACILITY LOCATION INFORMATION 43. BILLING PROVIDER INFO & PAY (See Instructions)

# Line Items 17 and 17b

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



# EMC Equivalent Lines 17 and 17b

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

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



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR MUCC USE

11. RESERVED FOR MUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I, the patient or authorized person, authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be made to the party who accepts assignment below.

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

15. OTHER DATE

16. DATE OF BIRTH AND NUMBER TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

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

21. PHYSICIAN OR SUPPLIER INFORMATION

22. PHYSICIAN OR SUPPLIER INFORMATION

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. RESERVE MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ( )

## Line Item 18

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
18	Hospitalization dates related to current service (From and To)	2300	DTP03 (435)	Related hospitalization admission date	DTP01 Admission or Discharge qualifier 435 or 096
			DTP03 (096)	Related hospitalization discharge date	Enter the date when a medical service is furnished as a result of, or subsequent to, a related hospitalization. DTP (435) is required when 2300. CLM05-1 = 21, 51 or 61

# Line Item 19

- Certain claim submissions do not always require an attachment
  - Enter certain dates, facts or information about service(s)
    - Routine foot care
    - Hematocrit/hemoglobin
    - Homebound
    - Not otherwise classified codes/drugs
    - Shared post operative care
    - Demonstration/clinical trials
    - Anti-markup/purchased tests
    - Claim notes

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

PCIA ☐ NCA ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ SELF OR NON-EMPLOYEE ☐ OTHER ☐

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

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

CITY  STATE  8. RECEIPT NO. FOR NUCC USE  OFFICE  STATE

ZIP CODE  TELEPHONE (Include Area Code)  2. 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 OR GROUP OR FICA NUMBER

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

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

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

21. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO  IF YES, Complete Section 19, 20, and 21.

22. PATIENTS OR AUTHORIZED PERSONS SIGNATURE  I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than paid to the party who accepts assignment below.

23. INSURED'S OR AUTHORIZED PERSONS SIGNATURE  I authorize payment of medical benefits to the designated physician or supplier for services described below.

SIGNED  DATE  SIGNED

24. DATE OF CURRENT SURGERY, INJURY, OR PROGRAMMED CLAR  25. OTHER DATE  26. DATE OF LAST WORK IN CURRENT OCCUPATION

27. NAME OF REFERRING PROVIDER OR OTHER SOURCE  28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

30. OUTSIDE LAB?  YES  NO  31. PHYSICIAN OR SUPPLIER INFORMATION

32. PRIOR AUTHORIZATION NUMBER

33. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

34. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

35. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

36. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

37. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

38. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

39. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

40. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

41. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

42. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

43. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

44. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

45. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

46. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

47. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

48. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

49. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

50. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

51. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

52. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

53. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

54. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

55. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

56. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

57. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

58. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

59. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

60. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

61. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

62. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

63. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

64. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

65. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

66. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

67. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

68. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

69. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

70. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

71. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

72. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

73. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

74. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

75. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

76. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

77. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

78. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

79. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

80. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

81. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

82. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

83. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

84. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

85. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

86. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

87. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

88. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

89. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

90. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

91. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

92. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

93. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

94. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

95. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

96. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

97. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

98. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

99. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

100. A. DATES OF SERVICE  B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.





# EMC Equivalent Line 19

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

# Line Item 20

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

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

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 30-000 0012

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

2. PATIENT'S NAME (Last name, first name, middle initial)

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

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

8. PATIENT'S SEX (M/F)

9. PATIENT'S RELATIONSHIP TO INSURED

10. RESERVED FOR FUTURE USE

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

12. OTHER INSURED'S POLICY OR GROUP NUMBER

13. RESERVED FOR FUTURE USE

14. RESERVED FOR FUTURE USE

15. INSURED'S POLICY OR GROUP OR POLICY NUMBER

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

17. OTHER CLAIM ID (Designated by NCCI)

18. INSURANCE PLAN NAME OR PROGRAM NAME

19. IS THERE ANOTHER HEALTH BENEFIT PLAN?

20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include all, even if not related to claim)

22. PHYSICIAN OR SUPPLIER INFORMATION

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) B. PLACE OF SERVICE (Indicate office, home, etc.) C. PROCEDURE, SERVICE, OR SUPPLY (Indicate code, description, etc.) D. DIAGNOSIS (Indicate code, description, etc.) E. CHARGES (Indicate amount, etc.) F. AMOUNT PAID (Indicate amount, etc.) G. REVENUE (Indicate amount, etc.)

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. REVENUE (Indicate amount, etc.)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Indicate name, title, etc.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PIN# ( )

**CARQUEST**

## PATIENT AND INSURED INFORMATION

- NO CLAIMS OR SUPPLEMENTATION



# 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											
NCA											
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		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 RELATIONSHIP TO INSURED		6. INSURED'S NAME (Last Name, First Name, Middle Initial)		7. INSURED'S ADDRESS (No. Street)	
8. PATIENT'S ADDRESS (No. Street)		9. CITY		10. STATE		11. ZIP CODE		12. TELEPHONE (Include Area Code)		13. INSURED'S POLICY OR GROUP OR FICA NUMBER	
14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		15. IS PATIENT'S CONDITION RELATED TO:		16. EMPLOYMENT (Current or Former)		17. AUTO ACCIDENT?		18. OTHER CLAIM ID (Designated by NUCC)		19. INSURANCE PLAN NAME OR PROGRAM NAME	
20. OTHER INSURED'S POLICY OR GROUP NUMBER		21. IS PATIENT'S CONDITION RELATED TO:		22. EMPLOYMENT (Current or Former)		23. AUTO ACCIDENT?		24. OTHER CLAIM ID (Designated by NUCC)		25. INSURANCE PLAN NAME OR PROGRAM NAME	
26. RESUBMISSION CODE		27. ORIGINAL REF. NO.		28. DATE OF CURRENT SERVICE, INJURY, OR PROGRAMS (Last)		29. OTHER DATE		30. DATE OF CURRENT SERVICE, INJURY, OR PROGRAMS (Last)		31. OTHER DATE	
32. NAME OF REFERRING PROVIDER OR OTHER SOURCE		33. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		34. OUTSIDE LAB?		35. CHARGES		36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALIC code below ICD-9)		37. ICD-9	
38. A. DATES OF SERVICE		39. B. PROCEDURE, SERVICE, OR SUPPLY		40. C. CHARGES		41. D. PROVIDER OR SUPPLIER		42. E. CHARGES		43. F. CHARGES	
44. A. DATES OF SERVICE		45. B. PROCEDURE, SERVICE, OR SUPPLY		46. C. CHARGES		47. D. PROVIDER OR SUPPLIER		48. E. CHARGES		49. F. CHARGES	
50. FEDERAL TAX ID NUMBER		51. PATIENT'S ACCOUNT NO.		52. ACCOUNT ASSIGNMENT?		53. TOTAL CHARGE		54. AMOUNT PAID		55. RESUBMISSION CODE	
56. SIGNATURE OF PHYSICIAN OR SUPPLIER		57. SERVICE FACILITY LOCATION INFORMATION		58. BILLING PROVIDER INFO & Print		59. BILLING PROVIDER INFO & Print		60. BILLING PROVIDER INFO & Print		61. BILLING PROVIDER INFO & Print	

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (See Instructions)												14. INSURED'S ID NUMBER (For Program in Item 1)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)											
5. PATIENT'S ADDRESS (No. Street)												6. PATIENT'S RELATIONSHIP TO INSURED (See Instructions)											
CITY STATE ZIP CODE TELEPHONE (Include Area Code)												7. INSURED'S ADDRESS (No. Street)											
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												9. IS PRESENT CONDITION RELATED TO (See Instructions)											
4. OTHER INSURED'S POLICY OR GROUP NUMBER												10. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)											
5. RESERVED FOR MUCC USE												11. INSURED'S POLICY GROUP OR POLICY NUMBER											
6. RESERVED FOR MUCC USE												12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)											
4. INSURANCE PLAN NAME OR PROGRAM NAME												13. IS THERE ANOTHER HEALTH BENEFIT PLAN? (See Instructions)											
15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credit to be paid to the party who accepts assignment below.)																							
16. DATE OF CURRENT ILLNESS, INJURY, OR PREEXISTING CONDITION (MM/DD/YY) QUAL (See Instructions)												17. OTHER DATE (MM/DD/YY) QUAL (See Instructions)											
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE (See Instructions)												19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY TO MM/DD/YY)											
20. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)												21. OUTSIDE LAB? (See Instructions)											
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9 code and ICD-10 code)												23. PRIOR AUTHORIZATION NUMBER											
24. A. DATES OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) B. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM, ICD-10, HCPCS, CPT, or other code)												25. TOTAL CHARGE (See Instructions)											
26. PATIENT'S ACCOUNT NO.												27. ACCOUNT ASSIGNMENT? (YES/NO)											
28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office or facility)												29. SERVICE FACILITY LOCATION INFORMATION											
30. BILLING PROVIDER INFO & PAY (See Instructions)												31. BILLING PROVIDER INFO & PAY (See Instructions)											

## Line Item 23

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



# EMC Equivalent Line 23

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



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE 16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide AC code 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

# EMC Equivalent Lines 24A–24J

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





# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (See Instructions) 14. INSURED'S ID NUMBER (For Programs in Item 1)

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

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

CITY STATE 8. RESIDENT FOR NUCC USE CITY STATE

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

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

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE 16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, even those below ICD-9) 22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM B. C. D. PROVIDER, SERVICES, OR SUPPLIER (Designate Uninsured Organization) E. DIAGNOSIS F. HOSPITALIZATION

25. FEDERAL TAX ID. NUMBER SSN EIN

26. ACCOUNT NO. 27. CREDIT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. PROVIDER 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 OTHER (See Instructions) 16. INSURED'S ID NUMBER (For Programs in Item 1)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RECEIVED FOR NUCC USE OFF ( ) STATE 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 OR GROUP OR FICA NUMBER

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

15. RESERVED FOR NUCC USE 16. AUTO ACCIDENT? (See Instructions) 17. OTHER CLAIM ID (Designated by NUCC)

18. RESERVED FOR NUCC USE 19. OTHER ACCIDENT? (See Instructions) 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, or Yes, Complete Item 1, 16, and 17)

24. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to my right to the party who accepts assignment below.) 25. INSURED'S OR AUTHORIZED PERSONS SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

SIGNED DATE SIGNED

26. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 27. OTHER DATE 28. DATE OF AND WHERE WORK IN CURRENT OCCUPATION (MM, DD, YY) (MM, DD, YY)

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

31. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 32. OUTSIDE LAB? (Yes, No, or Yes, Complete Item 1, 16, and 17)

33. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all, even when below ICD-9-CM) 34. PHYSICIAN OR SUPPLIER (See Instructions) 35. PHYSICIAN OR SUPPLIER (See Instructions)

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

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the signature on this claim is my own and not made by a paid helper.) 32. BILLING PROVIDER INFO & Print ( )



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (For Programs in Item 1)

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR MUCC USE

11. RESERVED FOR MUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I, the patient or authorized person's signature, authorize the release of any medical or other information necessary to process this claim. I also request payment or government benefits due to me or to the party who accepts assignment below.

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

15. OTHER DATE

16. DATE OF BIRTH

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM code below)

20. PHYSICIAN OR SUPPLIER INFORMATION

21. ACCEPT ASSIGNMENT? (For bill date, see page 2)

22. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office or facility)

23. SERVICE FACILITY LOCATION INFORMATION

24. 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	CLM07	Assignment or Plan Participation code	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not assigned



# Line Items 28, 29 and 30

- Item 28 is total charges on claim
- Item 29 leave blank
  - Often misunderstood
  - Allocates payment to beneficiary
- Item 30 is not used

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
28	Total Charges	2300	CLM02	Total claim charge amount	Enter total charges for services.
29	Amount paid	2300	AMT02	Total patient amount paid	AMT01 Amount qualifier code=F5 Required if the patient has paid any amount towards the claim for covered services only.

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

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR NUCC USE

11. RESERVED FOR NUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. IS PATIENT'S CONDITION RELATED TO:

14. EMPLOYMENT (Current or Former)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (Designated by NUCC)

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

19. DATE

20. SIGNED

21. DATE OF CURRENT SURGICAL INJURY, IF PREVIOUSLY CLAIMED

22. OTHER DATE

23. NAME OF REFERRING PROVIDER OR OTHER SOURCE

24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

25. OUTSIDE LAB?

26. YES

27. NO

28. PRIOR AUTHORIZATION NUMBER

29. FEDERAL TAX ID NUMBER

30. PATIENT'S ACCOUNT NO.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials if party that the claim is to be paid to or the party who accepts assignment to the claim and not under a paid benefit)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PIN#

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Rsvd for NUCC Use

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

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

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

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

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

ZIP CODE TELEPHONE (Include Area Code) 10. ZIP CODE TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. EMPLOYMENT (Current or Former) 11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)

10. RESERVED FOR MUCC USE 11. AUTO ACCIDENT? (PLACE SIGN) 12. OTHER CLAIMED (Designated by MUCC)

11. RESERVED FOR MUCC USE 12. OTHER ACCIDENT? (YES/NO) 13. INSURANCE PLAN NAME OR PROGRAM NAME

12. INSURANCE PLAN NAME OR PROGRAM NAME 13. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) (Specify complete form 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100)

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 20. OUTSIDE CLAIM (YES/NO) (Specify)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide AC, ICD-10 code below) 22. PHYSICIAN OR OTHER PROVIDER (NAME, ADDRESS, PHONE NO.)

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

24. A. ADDRESS OF SERVICE (From/To) (MM/DD/YY) 25. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 26. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 27. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 28. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 29. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 30. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 31. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 32. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 33. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 34. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 35. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 36. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 37. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 38. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 39. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 40. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 41. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 42. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 43. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 44. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 45. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 46. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 47. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 48. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 49. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 50. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 51. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 52. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 53. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 54. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 55. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 56. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 57. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 58. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 59. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 60. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 61. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 62. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 63. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 64. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 65. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 66. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 67. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 68. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 69. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 70. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 71. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 72. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 73. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 74. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 75. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 76. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 77. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 78. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 79. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 80. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 81. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 82. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 83. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 84. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 85. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 86. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 87. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 88. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 89. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 90. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 91. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 92. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 93. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 94. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 95. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 96. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 97. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 98. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 99. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 100. PROVIDER'S ADDRESS (From/To) (MM/DD/YY)

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. ACCOUNT ASSIGNMENT (YES/NO) 34. TOTAL CHARGE 35. AMOUNT PAID 36. PROVIDER'S ADDRESS (From/To) (MM/DD/YY) 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



# Line Item 32

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DISC BOX (LINE 10) 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 (incl. Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (incl. Street)

8. CITY 9. STATE 10. RESIDENT FOR NUCC USE 11. OFFICE 12. STATE

13. ZIP CODE 14. TELEPHONE (include Area Code) 15. ZIP CODE 16. TELEPHONE (include Area Code)

17. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 18. IS PHYSICIAN'S CONDITION RELATED TO 19. INSURED'S POLICY OR GROUP OR PEOA NUMBER

20. OTHER INSURED'S POLICY OR GROUP NUMBER 21. EMPLOYMENT (Current or Previous) 22. INSURED'S DATE OF BIRTH (MM DD YY) SEX

23. RESERVED FOR NUCC USE 24. AUTO ACCIDENT? 25. PLACE (State) 26. OTHER CLAIMED (as guided by NUCC)

27. RESERVED FOR NUCC USE 28. OTHER ACCIDENT? 29. INSURANCE PLAN NAME OR PROGRAM NAME 30. IS THERE ANOTHER HEALTH BENEFIT PLAN?

31. CLAIM CODES (as guided by NUCC) 32. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (yes, complete Item 33, 34, and 35)

33. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government contribution to be paid to the party who accepts assignment below.) 34. DATE 35. SIGNED

36. DATE OF CURRENT SURVIVAL, INJURY, OR PREGNANCY (MM DD YY) 37. OTHER DATE (MM DD YY) 38. DATE OF BIRTH (MM DD YY) 39. DATE OF DEATH (MM DD YY)

39. NAME OF REFERRING PROVIDER OR OTHER SOURCE 40. ADDITIONAL CLAIM INFORMATION (as guided by NUCC)

41. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Nurse AC, Enter the below ICD-9) 42. ICD-9 43. ICD-9 44. ICD-9 45. ICD-9

46. A. B. C. D. E. F. G. H. I. J. K. L. 47. PRIOR AUTHORIZATION NUMBER

48. A. B. C. D. E. F. G. H. I. J. K. L. 49. PRIOR AUTHORIZATION NUMBER

50. DATE OF SERVICE From To 51. PLACE OF SERVICE 52. PROVIDER'S SIGNATURE OR SUPPLIER'S (Signatures of Unlicensed Health Professionals) 53. DIAGNOSIS POSITION 54. ICD-9 55. ICD-9 56. ICD-9 57. ICD-9

58. FEDERAL TAX ID NUMBER 59. SIGN 60. TOTAL CHARGE 61. AMOUNT PAID 62. RESERVED FOR NUCC USE

63. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials to carry that the statements on this reverse apply to this bill and are in full and final) 64. BILLING PROVIDER INFO & P# ( )

65. NPI 66. NPI



PCSA										PCSA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN ISCR NO. (USE) OTHER					10. 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)					7. INSURED'S ADDRESS (No. Street)						
CITY STATE ZIP CODE TELEPHONE (Include Area Code)					CITY STATE ZIP CODE TELEPHONE (Include Area Code)						
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:						
9. OTHER INSURED'S POLICY OR GROUP NUMBER					11. INSURED'S POLICY GROUP OR MEDA NUMBER						
5. RESERVED FOR MUCC USE					6. INSURED'S DATE OF BIRTH MM DD YY SEX M F						
6. RESERVED FOR MUCC USE					8. OTHER CLAIM ID (Designated by MUCC)						
7. RESERVED FOR MUCC USE					9. INSURANCE PLAN NAME OR PROGRAM NAME						
8. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (Type, complete Item 9, Yes, and No)						
<p><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> <p>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 release payment or government benefits either to myself or to the party who accepts assignment below.)</p> <p>SIGNED _____ DATE _____</p>											
14. DATE OF CURRENT SURVIVAL SURVIVAL FREQUENCY (LAST) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL						
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 MUCC)					20. OUTSIDE LAB? \$ CHARGE						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL, even those below ICD-9)					22. HMBB NUMBER CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER					24. A. DATE(s) OF SERVICE FROM MM DD YY TO MM DD YY B. PLACE OF SERVICE (ENR) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGE						
25. FEDERAL TAX ID NUMBER SIGN SIGN					26. TOTAL CHARGE \$ 27. AMOUNT PAID \$ 28. PAYEE MUCC USE						
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this form are apply to the bill and are in accordance with the terms of the contract.)					30. BILLING PROVIDER INFO & Pmt #						
31. SERVICE FACILITY LOCATION INFORMATION					32. BILLING PROVIDER INFO & Pmt #						

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

376	NPI	7310C	NM109 (77)	Laboratory/Facility Primary Identifier	Enter the NPI of the Service Facility. Enter "XX" in the NM106 to indicate the NPI is present in the NM109.
		2400C**	NM109 (77)		
		2400	PS101	Purchased service provider identifier	
		2420D	NM101	Identification code qualifier =OD	
		2300	NM106	Identification code=XX	
			NM109	Identification code	
			NM101	Identification code qualifier =QD	
			NM106	Identification code	
			NM109	Identification code	
			REF01	Reference Identification qualifier =UW	
		REF02	Mammogram FQA number		

# Line Items 33 and 33a

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

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

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

**INSURER'S INFORMATION**

1. MEDICARE MEDIGAP TRICARE CHAMPVA GROUP HEALTH PLAN (GHP) (GHP CODE) OTHER (OTHER CODE) 16. INSURED'S ID NUMBER (For Program in Item 1)

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

5. PATIENT'S ADDRESS (incl. State) 6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other) 7. INSURED'S ADDRESS (incl. State)

CITY STATE 8. RESERVED FOR FUTURE USE OFF 9. ZIP CODE TELEPHONE (include Area Code) 10. ZIP CODE TELEPHONE (include Area Code)

11. OTHER INSURED'S NAME (Last Name, First Name, Middle Name) 12. IS THIS PATIENT'S CONDITION RELATED TO 13. INSURED'S POLICY GROUP OR FICA NUMBER

14. OTHER INSURED'S POLICY OR GROUP NUMBER 15. EMPLOYMENT (Current or Former) YES NO 16. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)

17. RESERVED FOR FUTURE USE 18. AUTO ACCIDENT? YES NO 19. OTHER CLAIM ID (Designated by NUCC) 20. INSURANCE PLAN NAME OR PROGRAM NAME

21. RESERVED FOR FUTURE USE 22. OTHER ACCIDENT? YES NO 23. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete Item 9, 16, and 17)

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 benefits to either 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. DATE (MM/DD/YY) 27. SIGNATURE (MM/DD/YY) 28. CURRENT OCCUPATION (FROM TO) 29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO)

30. OUTPATIENT LAST (YES NO) 31. CHARGES (ORIGINAL REF NO) 32. PRIOR AUTHORIZATION NUMBER

33. BILLING PROVIDER INFO & P1 ( )

34. FEDERAL TAX ID NUMBER (SSN EIN) 35. PATIENT'S ACCOUNT NO. 36. ACCOUNT ASSIGNMENT? (YES NO) 37. SIGNATURE OF PHYSICIAN OR SUPPLIER (includes address or credentials (to certify that this statement or this invoice apply to this bill and use it with a past benefit)) 38. SERVICE FACILITY LOCATION INFORMATION

# Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

## Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

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

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

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

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



# Claim Rejection Reminders

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

# Resources, References and Tools

# Resources and References

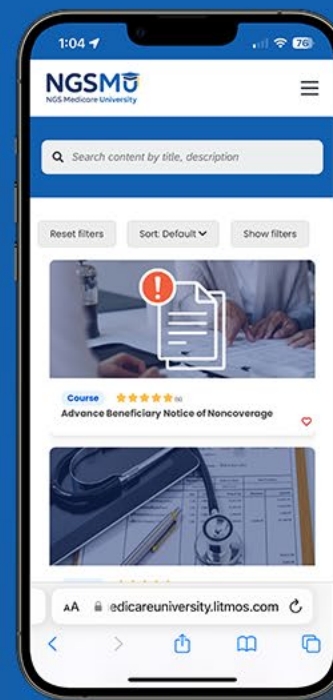
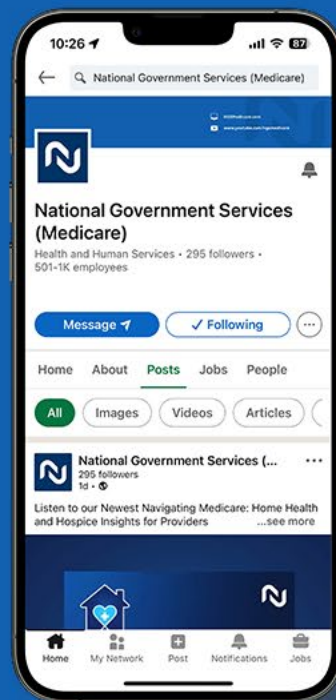
- [NGS website](#)
  - [CMS-1500 Claim Form Completion Instructions](#)
  - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)
  - [Top Claim Errors](#)
- [CMS website](#)
- [Place of Service Code Sets](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual](#)
  - [Chapter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



The background is a solid dark blue with a complex, abstract pattern of overlapping, semi-transparent geometric shapes in various shades of blue. These shapes include triangles, polygons, and curved forms, creating a layered, architectural effect. The overall composition is modern and minimalist.

# Questions?

Thank you!



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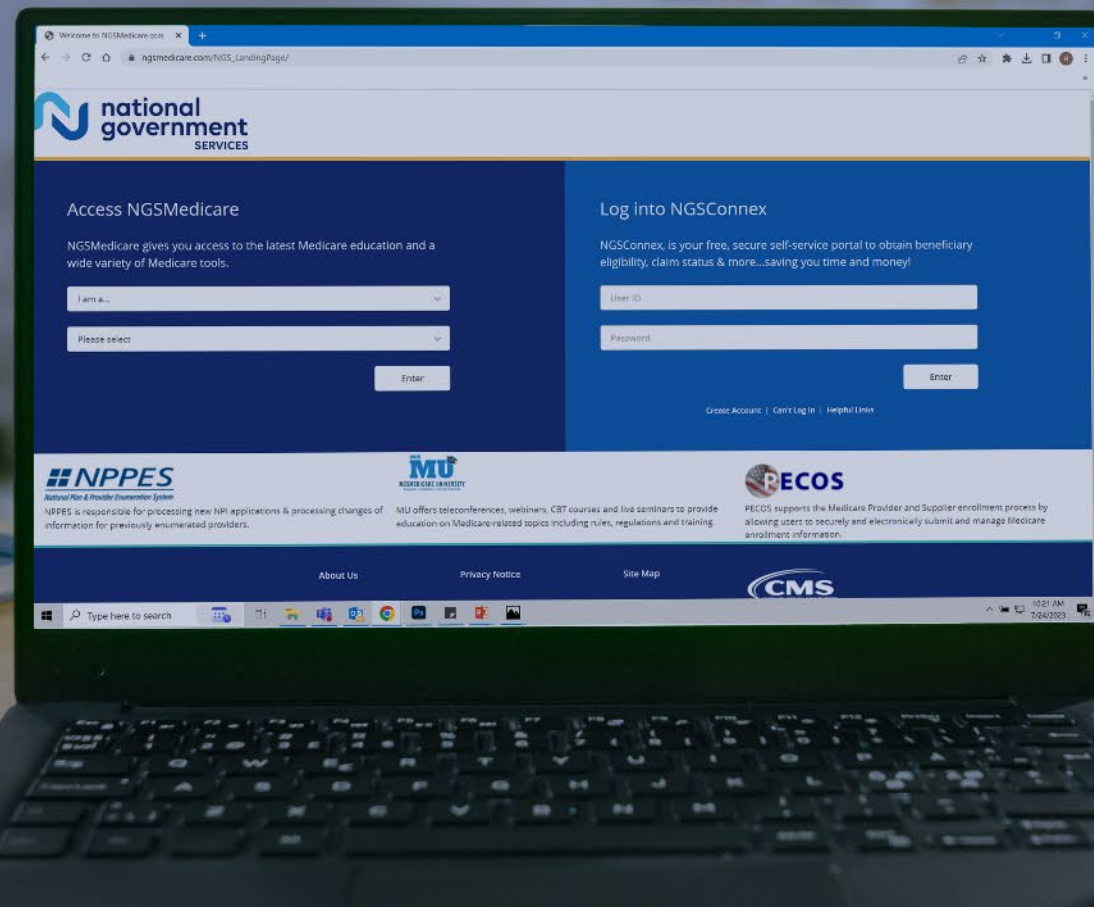


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