

Proper Medicare Part B Claim Submissions

6/27/2023

Today's Presenters

Provider Outreach and Education Consultants

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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.

Objectives

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

Claims Filing Time Limit

Administrative Simplification
Compliance Act

Paper and Electronic Claim Overview

Resources, References and Tools

Claim Form Requirements



Claim Submission Requirements

- Paper

- Original CMS-1500 Claim Form
- 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

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



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](#)

Claim Form Overview

CMS-1500 Claim Form (02/12)

The image shows a CMS-1500 Health Insurance Claim Form (02/12) with two yellow arrows pointing to specific sections. The first arrow, labeled 'Beneficiary data', points to the top section of the form, which includes fields for patient information such as name, address, and date of birth. The second arrow, labeled 'Provider data', points to the bottom section of the form, which includes fields for provider information such as name, address, and tax identification number. The form is divided into several sections, including 'PATIENT AND INSURER INFORMATION' and 'PROVIDER OR SUPPLIER INFORMATION'. The form is titled 'HEALTH INSURANCE CLAIM FORM' and includes a QR code in the top left corner.





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. PICK (Medicare) <input type="checkbox"/> MEDICARE (Medicaid) <input type="checkbox"/> TRICARE (DOWDUE) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> DECA (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										PICK (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. INSURED'S NAME (Last Name, First Name, Middle Initial)									
4. PATIENT'S ADDRESS (No., Street)										5. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
6. CITY										7. CITY									
8. STATE										9. STATE									
10. ZIP CODE										11. ZIP CODE									
12. TELEPHONE (Include Area Code)										13. TELEPHONE (Include Area Code)									
14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										15. IS PATIENT'S CONDITION RELATED TO:									
16. OTHER INSURED'S POLICY OR GROUP NUMBER										17. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
18. RESERVED FOR NUCC USE										19. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)									
20. RESERVED FOR NUCC USE										21. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
22. INSURANCE PLAN NAME OR PROGRAM NAME										23. CLAIM CODES (Designated by NUCC)									
24. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 10, and 11										25. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier to services described below.									
26. SIGNED _____ DATE _____										27. SIGNED _____ DATE _____									
28. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) MM DD YY										29. OTHER DATE QUAL _____ MM DD YY									
30. NAME OF REFERRING PROVIDER OR OTHER SOURCE										31. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
32. ADDITIONAL CLAIM INFORMATION (Or Designated by NUCC)										33. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
34. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Repeat ALL to cover line below)										35. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
36. PRIOR AUTHORIZATION NUMBER										37. PRIOR AUTHORIZATION NUMBER									
38. DATE(S) OF SERVICE From MM DD YY To MM DD YY										39. PLACE OF SERVICE SWR _____ SWG _____									
40. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) OPT/HCPCS _____ MODIFIER _____										41. DIAGNOSIS PORTER									
42. \$ CHARGES										43. \$ CHARGES									
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161. \$ CHARGES										162. \$ CHARGES									
163. \$ CHARGES										164. \$ CHARGES									
165. \$ CHARGES										166. \$ CHARGES									
167. \$ CHARGES										168. \$ CHARGES									
169. \$ CHARGES										170. \$ CHARGES									
171. \$ CHARGES										17									

Line Item 1

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

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
<input type="checkbox"/> (Medicare#)	<input type="checkbox"/> (Medicaid#)	<input type="checkbox"/> (ID#/DoD#)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)

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); if you use lowercase letters, our system will convert them to uppercase letters. MBIs are assigned by SSA

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

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) 02A2

1. MEDICARE MEDICAID TRICARE CHAMPVA OTHER HEALTH PLAN (OHP) FECA BOXING (ROW) OTHER (ROW)		14. 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 BIRTH DATE MM DD YY SEX M F		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		9. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
9. RESERVED FOR NUCC USE		10. OTHER CLAIM ID (Designated by NUCC)	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. EMPLOYMENT? (Current or Previous) YES NO		12. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. AUTO ACCIDENT? YES NO		13. OTHER CLAIM ID (Designated by NUCC)	
c. OTHER ACCIDENT? YES NO		14. INSURED'S POLICY GROUP OR FECA NUMBER	
15. INSURANCE PLAN NAME OR PROGRAM NAME		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO	
16. CLAIM CODES (Designated by NUCC)		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO	
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)			
18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)			
19. DATE			
20. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP FROM TO QUAL			
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE			
22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO			
23. OUTSIDE LAB? YES NO \$ CHARGES			
24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read A.L. to L. and use both S4B) ICD-9-CM			
25. RESUBMISSION CODE ORIGINAL REF. NO.			
26. PRIOR AUTHORIZATION NUMBER			
27. DATE(S) OF SERVICE From To PLACE OF SERVICE BMS			
28. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS MODIFIER			
29. DIAGNOSIS POINTER			
30. \$ CHARGES			
31. DAYS OF SERVICE			
32. \$ AMOUNT PAID			
33. PROVIDER NUCC USE			
34. 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.)			
35. SERVICE FACILITY LOCATION INFORMATION			
36. BILLING PROVIDER INFO & PH#			
37. FEDERAL TAX ID NUMBER SSN EIN			
38. PATIENT'S ACCOUNT NO.			
39. ACCEPT ASSIGNMENT? YES NO			
40. TOTAL CHARGE			
41. SERVICE FACILITY LOCATION INFORMATION			
42. BILLING PROVIDER INFO & PH#			
43. FEDERAL TAX ID NUMBER SSN EIN			
44. PATIENT'S ACCOUNT NO.			
45. ACCEPT ASSIGNMENT? YES NO			
46. TOTAL CHARGE			
47. SERVICE FACILITY LOCATION INFORMATION			
48. BILLING PROVIDER INFO & PH#			
49. FEDERAL TAX ID NUMBER SSN EIN			
50. PATIENT'S ACCOUNT NO.			
51. ACCEPT ASSIGNMENT? YES NO			
52. TOTAL CHARGE			
53. SERVICE FACILITY LOCATION INFORMATION			
54. BILLING PROVIDER INFO & PH#			
55. FEDERAL TAX ID NUMBER SSN EIN			
56. PATIENT'S ACCOUNT NO.			
57. ACCEPT ASSIGNMENT? YES NO			
58. TOTAL CHARGE			
59. SERVICE FACILITY LOCATION INFORMATION			
60. BILLING PROVIDER INFO & PH#			
61. FEDERAL TAX ID NUMBER SSN EIN			
62. PATIENT'S ACCOUNT NO.			
63. ACCEPT ASSIGNMENT? YES NO			
64. TOTAL CHARGE			
65. SERVICE FACILITY LOCATION INFORMATION			
66. BILLING PROVIDER INFO & PH#			
67. FEDERAL TAX ID NUMBER SSN EIN			
68. PATIENT'S ACCOUNT NO.			
69. ACCEPT ASSIGNMENT? YES NO			
70. TOTAL CHARGE			
71. SERVICE FACILITY LOCATION INFORMATION			
72. BILLING PROVIDER INFO & PH#			
73. FEDERAL TAX ID NUMBER SSN EIN			
74. PATIENT'S ACCOUNT NO.			
75. ACCEPT ASSIGNMENT? YES NO			
76. TOTAL CHARGE			
77. SERVICE FACILITY LOCATION INFORMATION			
78. BILLING PROVIDER INFO & PH#			
79. FEDERAL TAX ID NUMBER SSN EIN			
80. PATIENT'S ACCOUNT NO.			
81. ACCEPT ASSIGNMENT? YES NO			
82. TOTAL CHARGE			
83. SERVICE FACILITY LOCATION INFORMATION			
84. BILLING PROVIDER INFO & PH#			
85. FEDERAL TAX ID NUMBER SSN EIN			
86. PATIENT'S ACCOUNT NO.			
87. ACCEPT ASSIGNMENT? YES NO			
88. TOTAL CHARGE			
89. SERVICE FACILITY LOCATION INFORMATION			
90. BILLING PROVIDER INFO & PH#			
91. FEDERAL TAX ID NUMBER SSN EIN			
92. PATIENT'S ACCOUNT NO.			
93. ACCEPT ASSIGNMENT? YES NO			
94. TOTAL CHARGE			
95. SERVICE FACILITY LOCATION INFORMATION			
96. BILLING PROVIDER INFO & PH#			
97. FEDERAL TAX ID NUMBER SSN EIN			
98. PATIENT'S ACCOUNT NO.			
99. ACCEPT ASSIGNMENT? YES NO			
100. TOTAL CHARGE			
101. SERVICE FACILITY LOCATION INFORMATION			
102. BILLING PROVIDER INFO & PH#			
103. FEDERAL TAX ID NUMBER SSN EIN			
104. PATIENT'S ACCOUNT NO.			
105. ACCEPT ASSIGNMENT? YES NO			
106. TOTAL CHARGE			
107. SERVICE FACILITY LOCATION INFORMATION			
108. BILLING PROVIDER INFO & PH#			
109. FEDERAL TAX ID NUMBER SSN EIN			
110. PATIENT'S ACCOUNT NO.			
111. ACCEPT ASSIGNMENT? YES NO			
112. TOTAL CHARGE			
113. SERVICE FACILITY LOCATION INFORMATION			
114. BILLING PROVIDER INFO & PH#			
115. FEDERAL TAX ID NUMBER SSN EIN			
116. PATIENT'S ACCOUNT NO.			
117. ACCEPT ASSIGNMENT? YES NO			
118. TOTAL CHARGE			
119. SERVICE FACILITY LOCATION INFORMATION			
120. BILLING PROVIDER INFO & PH#			
121. FEDERAL TAX ID NUMBER SSN EIN			
122. PATIENT'S ACCOUNT NO.			
123. ACCEPT ASSIGNMENT? YES NO			
124. TOTAL CHARGE			
125. SERVICE FACILITY LOCATION INFORMATION			
126. BILLING PROVIDER INFO & PH#			
127. FEDERAL TAX ID NUMBER SSN EIN			
128. PATIENT'S ACCOUNT NO.			
129. ACCEPT ASSIGNMENT? YES NO			
130. TOTAL CHARGE			
131. SERVICE FACILITY LOCATION INFORMATION			
132. BILLING PROVIDER INFO & PH#			
133. FEDERAL TAX ID NUMBER SSN EIN			
134. PATIENT'S ACCOUNT NO.			
135. ACCEPT ASSIGNMENT? YES NO			
136. TOTAL CHARGE			
137. SERVICE FACILITY LOCATION INFORMATION			
138. BILLING PROVIDER INFO & PH#			
139. FEDERAL TAX ID NUMBER SSN EIN			
140. PATIENT'S ACCOUNT NO.			
141. ACCEPT ASSIGNMENT? YES NO			
142. TOTAL CHARGE			
143. SERVICE FACILITY LOCATION INFORMATION			
144. BILLING PROVIDER INFO & PH#			
145. FEDERAL TAX ID NUMBER SSN EIN			
146. PATIENT'S ACCOUNT NO.			
147. ACCEPT ASSIGNMENT? YES NO			
148. TOTAL CHARGE			
149. SERVICE FACILITY LOCATION INFORMATION			
150. BILLING PROVIDER INFO & PH#			
151. FEDERAL TAX ID NUMBER SSN EIN			
152. PATIENT'S ACCOUNT NO.			
153. ACCEPT ASSIGNMENT? YES NO			
154. TOTAL CHARGE			
155. SERVICE FACILITY LOCATION INFORMATION			
156. BILLING PROVIDER INFO & PH#			
157. FEDERAL TAX ID NUMBER SSN EIN			
158. PATIENT'S ACCOUNT NO.			
159. ACCEPT ASSIGNMENT? YES NO			
160. TOTAL CHARGE			
161. SERVICE FACILITY LOCATION INFORMATION			
162. BILLING PROVIDER INFO & PH#			
163. FEDERAL TAX ID NUMBER SSN EIN			
164. PATIENT'S ACCOUNT NO.			
165. ACCEPT ASSIGNMENT? YES NO			
166. TOTAL CHARGE			
167. SERVICE FACILITY LOCATION INFORMATION			
168. BILLING PROVIDER INFO & PH#			
169. FEDERAL TAX ID NUMBER SSN EIN			
170. PATIENT'S ACCOUNT NO.			
171. ACCEPT ASSIGNMENT? YES NO			
172. TOTAL CHARGE			
173. SERVICE FACILITY LOCATION INFORMATION			
174. BILLING PROVIDER INFO & PH#			
175. FEDERAL TAX ID NUMBER SSN EIN			
176. PATIENT'S ACCOUNT NO.			
177. ACCEPT ASSIGNMENT? YES NO			
178. TOTAL CHARGE			
179. SERVICE FACILITY LOCATION INFORMATION			
180. BILLING PROVIDER INFO & PH#			
181. FEDERAL TAX ID NUMBER SSN EIN			
182. PATIENT'S ACCOUNT NO.			
183. ACCEPT ASSIGNMENT? YES NO			
184. TOTAL CHARGE			
185. SERVICE FACILITY LOCATION INFORMATION			
186. BILLING PROVIDER INFO & PH#			
187. FEDERAL TAX ID NUMBER SSN EIN			
188. PATIENT'S ACCOUNT NO.			
189. ACCEPT ASSIGNMENT? YES NO			
190. TOTAL CHARGE			
191. SERVICE FACILITY LOCATION INFORMATION			
192. BILLING PROVIDER INFO & PH#			
193. FEDERAL TAX ID NUMBER SSN EIN			
194. PATIENT'S ACCOUNT NO.			
195. ACCEPT ASSIGNMENT? YES NO			
196. TOTAL CHARGE			
197. SERVICE FACILITY LOCATION INFORMATION			
198. BILLING PROVIDER INFO & PH#			
199. FEDERAL TAX ID NUMBER SSN EIN			
200. PATIENT'S ACCOUNT NO.			
201. ACCEPT ASSIGNMENT? YES NO			
202. TOTAL CHARGE			
203. SERVICE FACILITY LOCATION INFORMATION			
204. BILLING PROVIDER INFO & PH#			
205. FEDERAL TAX ID NUMBER SSN EIN			
206. PATIENT'S ACCOUNT NO.			
207. ACCEPT ASSIGNMENT? YES NO			
208. TOTAL CHARGE			
209. SERVICE FACILITY LOCATION INFORMATION			
210. BILLING PROVIDER INFO & PH#			
211. FEDERAL TAX ID NUMBER SSN EIN			
212. PATIENT'S ACCOUNT NO.			
213. ACCEPT ASSIGNMENT? YES NO			
214. TOTAL CHARGE			
215. SERVICE FACILITY LOCATION INFORMATION			
216. BILLING PROVIDER INFO & PH#			
217. FEDERAL TAX ID NUMBER SSN EIN			
218. PATIENT'S ACCOUNT NO.			
219. ACCEPT ASSIGNMENT? YES NO			
220. TOTAL CHARGE			
221. SERVICE FACILITY LOCATION INFORMATION			
222. BILLING PROVIDER INFO & PH#			
223. FEDERAL TAX ID NUMBER SSN EIN			
224. PATIENT'S ACCOUNT NO.			
225. ACCEPT ASSIGNMENT? YES NO			
226. TOTAL CHARGE			
227. SERVICE FACILITY LOCATION INFORMATION			
228. BILLING PROVIDER INFO & PH#			
229. FEDERAL TAX ID NUMBER SSN EIN			
230. PATIENT'S ACCOUNT NO.			
231. ACCEPT ASSIGNMENT? YES NO			
232. TOTAL CHARGE			
233. SERVICE FACILITY LOCATION INFORMATION			
234. BILLING PROVIDER INFO & PH#			
235. FEDERAL TAX ID NUMBER SSN EIN			
236. PATIENT'S ACCOUNT NO.			
237. ACCEPT ASSIGNMENT? YES NO			
238. TOTAL CHARGE			
239. SERVICE FACILITY LOCATION INFORMATION			
240. BILLING PROVIDER INFO & PH#			
241. FEDERAL TAX ID NUMBER SSN EIN			
242. PATIENT'S ACCOUNT NO.			
243. ACCEPT ASSIGNMENT? YES NO			
244. TOTAL CHARGE			
245. SERVICE FACILITY LOCATION INFORMATION			
246. BILLING PROVIDER INFO & PH#			
247. FEDERAL TAX ID NUMBER SSN EIN			
248. PATIENT'S ACCOUNT NO.			
249. ACCEPT ASSIGNMENT? YES NO			
250. TOTAL CHARGE			
251. SERVICE FACILITY LOCATION INFORMATION			
252. BILLING PROVIDER INFO & PH#			
253. FEDERAL TAX ID NUMBER SSN EIN			
254. PATIENT'S ACCOUNT NO.			
255. ACCEPT ASSIGNMENT? YES NO			
256. TOTAL CHARGE			
257. SERVICE FACILITY LOCATION INFORMATION			
258. BILLING PROVIDER INFO & PH#			
259. FEDERAL TAX ID NUMBER SSN EIN			
260. PATIENT'S ACCOUNT NO.			
261. ACCEPT ASSIGNMENT? YES NO			
262. TOTAL CHARGE			
263. SERVICE FACILITY LOCATION INFORMATION			
264. BILLING PROVIDER INFO & PH#			
265. FEDERAL TAX ID NUMBER SSN EIN			
266. PATIENT'S ACCOUNT NO.			
267. ACCEPT ASSIGNMENT? YES NO			
268. TOTAL CHARGE			
269. SERVICE FACILITY LOCATION INFORMATION			
270. BILLING PROVIDER INFO & PH#			
271. FEDERAL TAX ID NUMBER SSN EIN			
272. PATIENT'S ACCOUNT NO.			
273. ACCEPT ASSIGNMENT? YES NO			
274. TOTAL CHARGE			
275. SERVICE FACILITY LOCATION INFORMATION			
276. BILLING PROVIDER INFO & PH#			
277. FEDERAL TAX ID NUMBER SSN EIN			
278. PATIENT'S ACCOUNT NO.			
279. ACCEPT ASSIGNMENT? YES NO			
280. TOTAL CHARGE			
281. SERVICE FACILITY LOCATION INFORMATION			
282. BILLING PROVIDER INFO & PH#			
283. FEDERAL TAX ID NUMBER SSN EIN			
284. PATIENT'S ACCOUNT NO.			
285. ACCEPT ASSIGNMENT? YES NO			
286. TOTAL CHARGE			
287. SERVICE FACILITY LOCATION INFORMATION			
288. BILLING PROVIDER INFO & PH#			
289. FEDERAL TAX ID NUMBER SSN EIN			
290. PATIENT'S ACCOUNT NO.			
291. ACCEPT ASSIGNMENT? YES NO			
292. TOTAL CHARGE			
293. SERVICE FACILITY LOCATION INFORMATION			
294. BILLING PROVIDER INFO & PH#			
295. FEDERAL TAX ID NUMBER SSN EIN			
296. PATIENT'S ACCOUNT NO.			
297. ACCEPT ASSIGNMENT? YES NO			
298. TOTAL CHARGE			
299. SERVICE FACILITY LOCATION INFORMATION			
300. BILLING PROVIDER INFO & PH#			
301. FEDERAL TAX ID NUMBER SSN EIN			
302. PATIENT'S ACCOUNT NO.			
303. ACCEPT ASSIGNMENT? YES NO			
304. TOTAL CHARGE			
305. SERVICE FACILITY LOCATION INFORMATION			
306. BILLING PROVIDER INFO & PH#			
307. FEDERAL TAX ID NUMBER SSN EIN			
308. PATIENT'S ACCOUNT NO.			
309. ACCEPT ASSIGNMENT? YES NO			
310. TOTAL CHARGE			
311. SERVICE FACILITY LOCATION INFORMATION			
312. BILLING PROVIDER INFO & PH#			
313. FEDERAL TAX ID NUMBER SSN EIN			
314. PATIENT'S ACCOUNT NO.			
315. ACCEPT ASSIGNMENT? YES NO			
316. TOTAL CHARGE			
317. SERVICE FACILITY LOCATION INFORMATION			
318. BILLING PROVIDER INFO & PH#			
319. FEDERAL TAX ID NUMBER SSN EIN			
320. PATIENT'S ACCOUNT NO.			
321. ACCEPT ASSIGNMENT? YES NO			
322. TOTAL CHARGE			
323. SERVICE FACILITY LOCATION INFORMATION			
324. BILLING PROVIDER INFO & PH#			
325. FEDERAL TAX ID NUMBER SSN EIN			
326. PATIENT'S ACCOUNT NO.			
327. ACCEPT ASSIGNMENT? YES NO			
328. TOTAL CHARGE			
329. SERVICE FACILITY LOCATION INFORMATION			
330. BILLING PROVIDER INFO & PH#			
331. FEDERAL TAX ID NUMBER SSN EIN			
332. PATIENT'S ACCOUNT NO.			
333. ACCEPT ASSIGNMENT? YES NO			
334. TOTAL CHARGE			
335. SERVICE FACILITY LOCATION INFORMATION			
336. BILLING PROVIDER INFO & PH#			
337. FEDERAL TAX ID NUMBER SSN EIN			
338. PATIENT'S ACCOUNT NO.			
339. ACCEPT ASSIGNMENT? YES NO			
340. TOTAL CHARGE			
341. SERVICE FACILITY LOCATION INFORMATION			
342. BILLING PROVIDER INFO & PH#			
343. FEDERAL TAX ID NUMBER SSN EIN			
344. PATIENT'S ACCOUNT NO.			
345. ACCEPT ASSIGNMENT? YES NO			
346. TOTAL CHARGE			
347. SERVICE FACILITY LOCATION INFORMATION			
348. BILLING PROVIDER INFO & PH#			
349. FEDERAL TAX ID NUMBER SSN EIN			
350. PATIENT'S ACCOUNT NO.			
351. ACCEPT ASSIGNMENT? YES NO			
352. TOTAL CHARGE			
353. SERVICE FACILITY LOCATION INFORMATION			
354. BILLING PROVIDER INFO & PH#			
355. FEDERAL TAX ID NUMBER SSN EIN			
356. PATIENT'S ACCOUNT NO.			
357. ACCEPT ASSIGNMENT? YES NO			
358. TOTAL CHARGE			
359. SERVICE FACILITY LOCATION INFORMATION			
360. BILLING PROVIDER INFO & PH#			
361. FEDERAL TAX ID NUMBER SSN EIN			
362. PATIENT'S ACCOUNT NO.			
363. ACCEPT ASSIGNMENT? YES NO			
364. TOTAL CHARGE			
365. SERVICE FACILITY LOCATION INFORMATION			
366. BILLING PROVIDER INFO & PH#			
367. FEDERAL TAX ID NUMBER SSN EIN			
368. PATIENT'S ACCOUNT NO.			
369. ACCEPT ASSIGNMENT? YES NO			
370. TOTAL CHARGE			
371. SERVICE FACILITY LOCATION INFORMATION			
372. BILLING PROVIDER INFO & PH#			
373. FEDERAL TAX ID NUMBER SSN EIN			
374. PATIENT'S ACCOUNT NO.			
375. ACCEPT ASSIGNMENT? YES NO			
376. TOTAL CHARGE			
377. SERVICE FACILITY LOCATION INFORMATION			
378. BILLING PROVIDER INFO & PH#			
379. FEDERAL TAX ID NUMBER SSN EIN			
380. PATIENT'S ACCOUNT NO.			
381. ACCEPT ASSIGNMENT? YES NO			
382. TOTAL CHARGE			
383. SERVICE FACILITY LOCATION INFORMATION			
384. BILLING PROVIDER INFO & PH#			
385. FEDERAL TAX ID NUMBER SSN EIN			
386. PATIENT'S ACCOUNT NO.			
387. ACCEPT ASSIGNMENT? YES NO			
388. TOTAL CHARGE			
389. SERVICE FACILITY LOCATION INFORMATION			
390. BILLING PROVIDER INFO & PH#			
391. FEDERAL TAX ID NUMBER SSN EIN			
392. PATIENT'S ACCOUNT NO.			
393. ACCEPT ASSIGNMENT? YES NO			
394. TOTAL CHARGE			
395. SERVICE FACILITY LOCATION INFORMATION			
396. BILLING PROVIDER INFO & PH#			
397. FEDERAL TAX ID NUMBER SSN EIN			
398. PATIENT'S ACCOUNT NO.			
399. ACCEPT ASSIGNMENT? YES NO			
400. TOTAL CHARGE			
401. SERVICE FACILITY LOCATION INFORMATION			
402. BILLING PROVIDER INFO & PH#			
403. FEDERAL TAX ID NUMBER SSN EIN			
404. PATIENT'S ACCOUNT NO.			
405. ACCEPT ASSIGNMENT? YES NO			
406. TOTAL CHARGE			
407. SERVICE FACILITY LOCATION INFORMATION			
408. BILLING PROVIDER INFO & PH#			
409. FEDERAL TAX ID NUMBER SSN EIN			
410. PATIENT'S ACCOUNT NO.			
411. ACCEPT ASSIGNMENT? YES NO			
412. TOTAL CHARGE			
413. SERVICE FACILITY LOCATION INFORMATION			
414. BILLING PROVIDER INFO & PH#			
415. FEDERAL TAX ID NUMBER SSN EIN			
416. PATIENT'S ACCOUNT NO.			
417. ACCEPT ASSIGNMENT? YES NO			
418. TOTAL CHARGE			
419. SERVICE FACILITY LOCATION INFORMATION			
420. BILLING PROVIDER INFO & PH#			
421. FEDERAL TAX ID NUMBER SSN EIN			
422. PATIENT'S ACCOUNT NO.			
423. ACCEPT ASSIGNMENT? YES NO			
424. TOTAL CHARGE			
425. SERVICE FACILITY LOCATION INFORMATION			
426. BILLING PROVIDER INFO & PH#			
427. FEDERAL TAX ID NUMBER SSN EIN			
428. PATIENT'S ACCOUNT NO.			
429. ACCEPT ASSIGNMENT? YES NO			
430. TOTAL CHARGE			
431. SERVICE FACILITY LOCATION INFORMATION			
432. BILLING PROVIDER INFO & PH#			
433. FEDERAL TAX ID NUMBER SSN EIN			
434. PATIENT'S ACCOUNT NO.			
435. ACCEPT ASSIGNMENT? YES NO			
436. TOTAL CHARGE			
437. SERVICE FACILITY LOCATION INFORMATION			
438. BILLING PROVIDER INFO & PH#			
439. FEDERAL TAX ID NUMBER SSN EIN			
440. PATIENT'S ACCOUNT NO.			
441. ACCEPT ASSIGNMENT? YES NO			
442. TOTAL CHARGE			
443. SERVICE FACILITY LOCATION INFORMATION			
444. BILLING PROVIDER INFO & PH#			
445. FEDERAL TAX ID NUMBER SSN EIN			
446. PATIENT'S ACCOUNT NO.			
447. ACCEPT ASSIGNMENT? YES NO			
448. TOTAL CHARGE			
449. SERVICE FACILITY LOCATION INFORMATION			
450. BILLING PROVIDER INFO & PH#			
451. FEDERAL TAX ID NUMBER SSN EIN			
452. PATIENT'S ACCOUNT NO.			
453. ACCEPT ASSIGNMENT? YES NO			
454. TOTAL CHARGE			
455. SERVICE FACILITY LOCATION INFORMATION			
456. BILLING PROVIDER INFO & PH#			
457. FEDERAL TAX ID NUMBER SSN EIN			
458. PATIENT'S ACCOUNT NO.			
459. ACCEPT ASSIGNMENT? YES NO			

- 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) 02/02

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (Tricare) <input type="checkbox"/> CHAMPVA (Champion Victory) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO:		12. INSURED'S DATE OF BIRTH	
a. EMPLOYMENT? (Current or Previous)		b. OTHER CLAIM ID (Designated by NUCC)	
c. AUTO ACCIDENT? (Place (State))		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. OTHER ACCIDENT? (Place (State))		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
e. OTHER ACCIDENT? (Place (State))		e. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
f. INSURANCE PLAN NAME OR PROGRAM NAME		f. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
g. CLAIM CODES (Designated by NUCC)		g. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP)	
15. OTHER DATE		16. DATES 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 LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to determine both ICD and CPT)		22. PRIOR AUTHORIZATION NUMBER	
23. DATE(S) OF SERVICE		24. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (Yes/No)		28. TOTAL CHARGE	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials)		30. AMOUNT PAID	
31. SERVICE FACILITY LOCATION INFORMATION		32. BILLING PROVIDER INFO & PH#	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials)		34. BILLING PROVIDER INFO & PH#	

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

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

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

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

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) 02/22

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

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

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

CITY STATE CITY STATE

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

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

10. INSURED'S DATE OF BIRTH MM YY SEX 12. OTHER CLAIM ID (Designated by NUCC)

13. INSURANCE PLAN NAME OR PROGRAM NAME 14. CLAIM CODES (Designated by NUCC) 15. IS THERE ANOTHER HEALTH BENEFIT PLAN?

16. YES NO If yes, complete items 19, 20, and 21

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

19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY ONSET QUAL MM YY 20. OTHER DATE QUAL MM YY

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM YY TO MM YY

23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 24. OUTSIDE LAB? YES NO 25. CHARGE?

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in as many as apply) ICD-10 MS 27. RESUBMISSION CODE ORIGINAL REF. NO.

28. PRIOR AUTHORIZATION NUMBER

29. DATES OF SERVICE From To 30. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances) 31. DIAGNOSIS MONITOR 32. CHARGE 33. DATE OF BIRTH 34. SEX 35. QUAL 36. RENDERING PROVIDER ID #

1 2 3 4 5 6

37. RECURRENCE I.D. NUMBER 38. PATIENT'S ACCOUNT NO. 39. ACCOUNT ASSIGNMENT? YES NO 40. TOTAL CHARGE 41. AMOUNT PAID 42. Fee for NUCC Use

43. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to the bill and is made in good faith.) 44. SERVICE FACILITY LOCATION INFORMATION 45. BILLING PROVIDER INFO & PAY# ()

SIGNED DATE SIGNED DATE

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Clear Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (Tricare) <input type="checkbox"/> CHAMPVA (Champion) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BOX CLING (FECA Box Cling) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. 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)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street)		8. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete Item 9, 10, and 11		14. 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 benefit.)	
15. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL. (MM/DD/YY)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to determine both ICD and CPT)		22. PRIOR AUTHORIZATION NUMBER	
23. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) PLACE OF SERVICE (BMS) CPT/HCPCS (Diagnosis, Services, or Supplies) MODIFIER		24. DIAGNOSIS POINTER	
25. FEDERAL TAX I.D. NUMBER (SSN, EIN)		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (No prior bill, per USR) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. PROVIDER NUCC USE	
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. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH# ()		34. NPI	

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PLEASE PRINT OR TYPE

APPROVED CMB-0038-1197 FORM 100102-12



Line Item 6

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

6. PATIENT RELATIONSHIP TO INSURED			
Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>

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	

- 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

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

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) (2/72)

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> SECA <input type="checkbox"/> OTHER										1a. INSURED'S I.D. NUMBER (For Programs 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. INSURED'S ADDRESS (No. Street)									
6. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
8. CITY										9. STATE									
10. ZIP CODE										11. TELEPHONE (Include Area Code)									
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										13. IS PATIENT'S CONDITION RELATED TO:									
14. OTHER INSURED'S POLICY OR GROUP NUMBER										15. EMPLOYMENT (Current or Previous) YES NO									
16. RESERVED FOR NUCC USE										17. AUTO ACCIDENT PLACE (State) YES NO									
18. RESERVED FOR NUCC USE										19. OTHER ACCIDENT YES NO									
20. INSURANCE PLAN NAME OR PROGRAM NAME										21. CLAIM CODES (Designated by NUCC)									
READ BACK OF FORM BEFORE COMPLETING & SENDING THIS FORM.																			
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 either to myself or to the party who accepts assignment below.																			
23. SIGNED										24. DATE									
25. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY CLAIM										26. OTHER DATE									
27. NAME OF REFERRING PROVIDER OR OTHER SOURCE										28. HORIZONTALIZATION DATES RELATED TO CURRENT SERVICES									
29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										30. OUTSIDE LAB? YES NO \$ CHARGES									
31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Please fill in to avoid the below rates										32. REGISTRATION CODE ORIGINAL REF. NO.									
33. A B C D E										34. PRIOR AUTHORIZATION NUMBER									
35. A B C D E										36. PRIOR AUTHORIZATION NUMBER									
37. A B C D E										38. PRIOR AUTHORIZATION NUMBER									
39. A B C D E										40. PRIOR AUTHORIZATION NUMBER									
41. A B C D E										42. PRIOR AUTHORIZATION NUMBER									
43. A B C D E										44. PRIOR AUTHORIZATION NUMBER									
45. A B C D E										46. PRIOR AUTHORIZATION NUMBER									
47. A B C D E										48. PRIOR AUTHORIZATION NUMBER									
49. A B C D E										50. PRIOR AUTHORIZATION NUMBER									
51. A B C D E										52. PRIOR AUTHORIZATION NUMBER									
53. A B C D E										54. PRIOR AUTHORIZATION NUMBER									
55. A B C D E										56. PRIOR AUTHORIZATION NUMBER									
57. A B C D E										58. PRIOR AUTHORIZATION NUMBER									
59. A B C D E										60. PRIOR AUTHORIZATION NUMBER									
61. A B C D E										62. PRIOR AUTHORIZATION NUMBER									
63. A B C D E										64. PRIOR AUTHORIZATION NUMBER									
65. A B C D E										66. PRIOR AUTHORIZATION NUMBER									
67. A B C D E										68. PRIOR AUTHORIZATION NUMBER									
69. A B C D E										70. PRIOR AUTHORIZATION NUMBER									
71. A B C D E										72. PRIOR AUTHORIZATION NUMBER									
73. A B C D E										74. PRIOR AUTHORIZATION NUMBER									
75. A B C D E										76. PRIOR AUTHORIZATION NUMBER									
77. A B C D E										78. PRIOR AUTHORIZATION NUMBER									
79. A B C D E										80. PRIOR AUTHORIZATION NUMBER									
81. A B C D E										82. PRIOR AUTHORIZATION NUMBER									
83. A B C D E										84. PRIOR AUTHORIZATION NUMBER									
85. A B C D E										86. PRIOR AUTHORIZATION NUMBER									
87. A B C D E										88. PRIOR AUTHORIZATION NUMBER									
89. A B C D E										90. PRIOR AUTHORIZATION NUMBER									
91. A B C D E										92. PRIOR AUTHORIZATION NUMBER									
93. A B C D E										94. PRIOR AUTHORIZATION NUMBER									
95. A B C D E										96. PRIOR AUTHORIZATION NUMBER									
97. A B C D E										98. PRIOR AUTHORIZATION NUMBER									
99. A B C D E										100. PRIOR AUTHORIZATION NUMBER									

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHIP/PA (CHIP/PA) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BOXING (FECA BOXING) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. 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)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Grandchild, Other)	
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:	
4. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		c. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		d. OTHER CLAIM? (Designated by NUCC)	
3. INSURANCE PLAN NAME OR PROGRAM NAME		13a. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assigned benefit.)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL.		15. OTHER DATE (MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read A.L. to L. and use both S4B)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (Diagnose Unusual Circumstances) D. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OF SERVICE H. I.D. NO. I. D. NO. J. RENDERING PROVIDER ID #	
25. FEDERAL TAX ID NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. 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.)		28. SERVICE FACILITY LOCATION INFORMATION	
29. BILLING PROVIDER INFO & PH #		30. BILLING PROVIDER NPI	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0938-1197 FORM 1700102-12



Line Item 8

- Reserved for future NUCC use
- Not mapped electronically

8. RESERVED FOR NUCC USE

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](#)

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

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/22

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ MEDIGAP ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐ 1a. INSURED'S I.D. NUMBER (For Programs 1-10)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE 9. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? d. CLAIM CODES (Designated by NUCC)

10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.) 11. INSURED'S POLICY OR GROUP OR FECA NUMBER 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 13. OTHER CLAIM ID (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) If yes, complete items 16, 17, and 18.

PHYSICIAN OR SUPPLIER INFORMATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YY) TO (MM/DD/YY) 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/DD/YY) TO (MM/DD/YY) 18. OUTSIDE LAB? (Yes/No) 19. RESUBMISSION CODE 20. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in all applicable boxes) 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. 22. REVISION CODE 23. ORIGINAL REF. NO.

24. 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. 25. PATIENT'S ACCOUNT NO. 26. ACCOUNT ASSIGNMENT? (Yes/No) 27. TOTAL CHARGE \$ 28. AMOUNT PAID \$ 29. BILLING PROVIDER INFO & PH# ()

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PH# ()


33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 34. SERVICE FACILITY LOCATION INFORMATION 35. BILLING PROVIDER INFO & PH# ()

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 (FORM 10-02-12) Clear Form

EMC Equivalent Lines 9, 9a-9d

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
9*	Other insured's Name (Last, First, Middle Initial)	2333A	NM103	Other insured last name	Name of insured for Medigap plan
			NM104	Other insured first name	
			NM105	Other insured middle name	
9a*	Other insured's policy or group number (Medigap only)	2333A	NM106	Identification Code Qualifier (M Member Identification Number)	Medigap policy ID
			NM108	Other insured identifier	Medigap P Primary S Secondary T Tertiary
		2320	SR031	Payer responsibility	
			SR033	Insured group or policy number	Enter the insured's group or plan number
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	2333B	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	2333B	NM106	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) 02/12

1. MEDICARE ☐ **MEDICAID** ☐ **TRICARE** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN (GHP)** ☐ **FECA BOXING (FOW)** ☐ **OTHER** ☐

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **5. PATIENT RELATIONSHIP TO INSURED** Self Spouse Child Other

6. PATIENT'S ADDRESS (No. & Street) **7. INSURED'S ADDRESS** (No. & Street)

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

11. INSURED'S POLICY GROUP OR FECA NUMBER **12. INSURED'S DATE OF BIRTH** MM DD YY **SEX** M F

13. 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

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

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to ensure the best G4S) ICD-9-CM **22. RESUBMISSION 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** **C. PROCEDURES, SERVICES, OR SUPPLIES** (Specify Unusual Circumstances) **D. DIAGNOSIS POINTER** **E. \$ CHARGES** **F. DAYS OF SERVICE** **G. DATE OF SERVICE** **H. ICD-9-CM** **I. RENDERING PROVIDER ID #**

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

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. SERVICE FACILITY LOCATION INFORMATION** **33. BILLING PROVIDER INFO & PH #** ()

34. NPI **35. NPI**

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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

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

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

10d. CLAIM CODES (Designated by NUCC)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/22

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐ 1a. INSURED'S I.D. NUMBER (For Programs 1a-1c)

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 NEP Spouse Other Other 7. INSURED'S ADDRESS (No. Street)

CITY STATE CITY STATE

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

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 10. INSURED'S POLICY OR GROUP OR FECA NUMBER

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

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

16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than myself or to the party who accepts assignment of benefits.) 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM / DD / YY TO MM / DD / YY

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

19. NAME OF REFERRING PROVIDER OR OTHER SOURCE 20. OUTSIDE LAB? YES NO 21. EXAMINER OR NATURE OF LABS OR IMAGING Tests: All to be completed by GPO ICD-9S

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

24. 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. 25. PROCEDURES, SERVICES OR SUPPLIES (Specify Usual, Unusual, Circumstances, or FACTORS) 26. DIAGNOSIS MONITOR 27. CHARGES 28. DATE OF BIRTH MM / DD / YY 29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 30. SERVICE FACILITY LOCATION INFORMATION 31. BILLING PROVIDER INFO & PH# 32. SIGNATURE OF PHYSICIAN OR SUPPLIER 33. DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 FORM 1000 (02-22)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (Tricare) <input type="checkbox"/> CHAMPVA (Champion) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BOX CLING (FECA Box Cling) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. 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)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. OTHER CLAIM ID (Designated by NUCC)	
11. INSURANCE PLAN NAME OR PROGRAM NAME		12. CLAIM CODES (Designated by NUCC)	
13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		14. 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.)	
15. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)		16. OTHER DATE (MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to determine ICD-9) (ICD-9) (A-E) (F-J) (K-L) (M-N) (O-P) (Q-R) (S-T) (U-V) (W-X) (Y-Z)		22. PRIOR AUTHORIZATION NUMBER	
23. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) PLACE OF SERVICE (SN) (CPT/HCPCS) (Diagnosis) (ICD-9) (Diagnosis) (ICD-9) (Diagnosis) (ICD-9)		24. TOTAL CHARGE \$ CHARGES	
25. FEDERAL TAX ID NUMBER (SSN) (EIN)		26. PATIENT'S ACCOUNT NO.	
27. 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.)		28. SERVICE FACILITY LOCATION INFORMATION	
29. BILLING PROVIDER INFO & PH#		30. BILLING PROVIDER INFO & PH#	

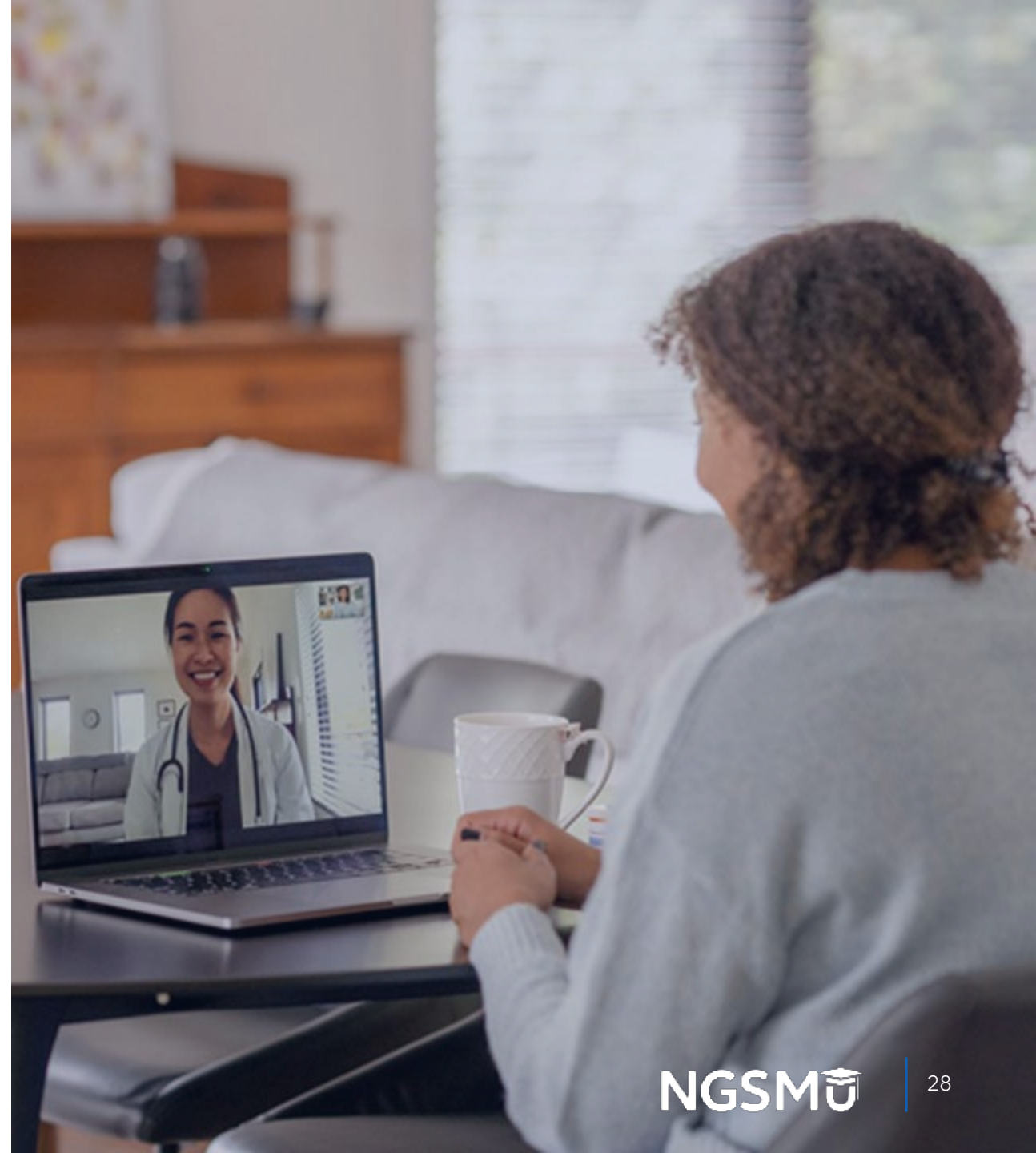
Line Items 11,11a-11d

- 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

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	

EMC Equivalent Lines 11, 11a-11c

- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)
- [Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P](#)
 - Indication of MSP
 - Insurance type code
 - Coordination of Benefits Payer Paid Amount – Claim Level
 - Coordination of Benefits Allowed Amount – Claim Level
 - Claim Contract Information – Claim Level
 - Claim Adjudication Date – Claim Level
 - Line Adjudication Information
 - Line Adjustments
 - Line Adjudication Date





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (CHAMPVA) <input type="checkbox"/> OTHER HEALTH PLAN (Other Health Plan) <input type="checkbox"/> FECA BOX CLING (FECA Box Cling) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. 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)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)	
7. INSURED'S ADDRESS (No., Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)	
13. 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.)		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP (MM/DD/YY) QUAL ()	
15. OTHER DATE (MM/DD/YY) QUAL ()		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? (YES/NO) \$ CHARGES ()	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL to ensure the best care) (ICD-10) ()		22. RESUBMISSION 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 () C. PROCEDURES, SERVICES, OR SUPPLIES (Diagnose Unusual Circumstances) (CPT/HCPCS) () D. DIAGNOSIS POINTER () E. \$ CHARGES () F. DATE OF SERVICE () G. DATE OF SERVICE () H. DATE OF SERVICE () I. DATE OF SERVICE () J. RENDERING PROVIDER ID # ()	
25. FEDERAL TAX ID NUMBER ()		26. PATIENT'S ACCOUNT NO. ()	
27. ACCEPT ASSIGNMENT? (YES/NO) ()		28. TOTAL CHARGE () 29. AMOUNT PAID () 30. PROVIDER NUCC USE ()	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) ()		32. SERVICE FACILITY LOCATION INFORMATION ()	
33. BILLING PROVIDER INFO & PH # ()		34. BILLING PROVIDER INFO & PH # ()	

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____


Line Item 13

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

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

SIGNED _____

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/22

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

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

3. PATIENT'S BIRTH DATE MM / DD / YY **SEX** M ☐ F ☐

4. PATIENT'S ADDRESS (No. Street)

5. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

6. RESERVED FOR NUCC USE

7. INSURED'S POLICY OR GROUP NUMBER

8. INSURED'S DATE OF BIRTH MM / DD / YY **SEX** M ☐ F ☐

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 of government benefits other to myself or to the party who accepts assignment below.

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

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ **21. REIMBURSEMENT CODE** **22. PRIOR AUTHORIZATION NUMBER**

23. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual, Custom, or Necessary) **24. DIAGNOSIS MONITOR** **25. TOTAL CHARGE** \$ **26. AMOUNT PAID** \$ **27. BILLING PROVIDER INFO & PH#** ()

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the customer is on the reverse apply this to and make a print there.) **29. SERVICE FACILITY LOCATION INFORMATION** **30. BILLING PROVIDER INFO & PH#** ()

31. SIGNATURE **32. DATE** **33. SIGNATURE** **34. DATE**

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

15. OTHER DATE MM / DD / YY **QUAL** ☐

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ **21. REIMBURSEMENT CODE** **22. PRIOR AUTHORIZATION NUMBER**

23. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual, Custom, or Necessary) **24. DIAGNOSIS MONITOR** **25. TOTAL CHARGE** \$ **26. AMOUNT PAID** \$ **27. BILLING PROVIDER INFO & PH#** ()

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the customer is on the reverse apply this to and make a print there.) **29. SERVICE FACILITY LOCATION INFORMATION** **30. BILLING PROVIDER INFO & PH#** ()

31. SIGNATURE **32. DATE** **33. SIGNATURE** **34. DATE**



NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0438-1197 FORM 100102-12

Line Item 14

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

31

Line Item 15

- Not required
- Not mapped electronically

15. OTHER DATE			
QUAL		MM	DD YY

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/2

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐ 1a. INSURED'S I.D. NUMBER (For Programs 1-5)

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

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

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

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO: ☐ YES ☐ NO 11. INSURED'S POLICY GROUP OR FECA NUMBER

10. OTHER INSURED'S POLICY OR GROUP NUMBER 10a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO 11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX ☐ M ☐ F

12. RESERVED FOR NUCC USE 12a. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) 12b. OTHER CLAIM ID (Designated by NUCC)

13. RESERVED FOR NUCC USE 13a. OTHER ACCIDENT? ☐ YES ☐ NO 13. INSURANCE PLAN NAME OR PROGRAM NAME

14. INSURANCE PLAN NAME OR PROGRAM NAME 14a. CLAIM CODES (Designated by NUCC) 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 14a, and 14b

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 of government benefits other to myself or to the party who accepts assignment below.) 15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YY) TO (MM/DD/YY)

16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM QUAL MM DD YY 16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/DD/YY) TO (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NP 17b. NP 17c. NP 17d. NP 17e. NP 17f. NP 17g. NP 17h. NP 17i. NP 17j. NP 17k. NP 17l. NP 17m. NP 17n. NP 17o. NP 17p. NP 17q. NP 17r. NP 17s. NP 17t. NP 17u. NP 17v. NP 17w. NP 17x. NP 17y. NP 17z. NP

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19. OUTSIDE LAST ☐ YES ☐ NO \$ CHARGES

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in all applicable boxes) ICD-9-CM 21. RESUBMISSION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

23. 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. 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.


24. 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. 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 I.D. NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? ☐ YES ☐ NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Fee for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this claim and is made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ()

34. SIGNATURE 35. DATE 36. NPI 37. NPI 38. NPI 39. NPI 40. NPI 41. NPI 42. NPI 43. NPI 44. NPI 45. NPI 46. NPI 47. NPI 48. NPI 49. NPI 50. NPI 51. NPI 52. NPI 53. NPI 54. NPI 55. NPI 56. NPI 57. NPI 58. NPI 59. NPI 60. NPI 61. NPI 62. NPI 63. NPI 64. NPI 65. NPI 66. NPI 67. NPI 68. NPI 69. NPI 70. NPI 71. NPI 72. NPI 73. NPI 74. NPI 75. NPI 76. NPI 77. NPI 78. NPI 79. NPI 80. NPI 81. NPI 82. NPI 83. NPI 84. NPI 85. NPI 86. NPI 87. NPI 88. NPI 89. NPI 90. NPI 91. NPI 92. NPI 93. NPI 94. NPI 95. NPI 96. NPI 97. NPI 98. NPI 99. NPI 100. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 FORM 1000 (02-12)

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

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHIP/PA ☐ GROUP HEALTH PLAN (GHP) ☐ OTHER ☐ 14. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

CITY STATE CITY STATE

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

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

10. INSURED'S POLICY OR GROUP NUMBER 11. INSURED'S DATE OF BIRTH MM DD YY SEX M F 12. OTHER CLAIM ID (Designated by NUCC)

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

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 DATE

18. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP FROM TO QUAL 19. OTHER DATE MM DD YY 20. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE 22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to ensure the best ICD-10) A B C D E F G H I J K L

24. A. DATE(S) OF SERVICE From To B. C. D. E. F. G. H. I. J. K. L. 25. PRIOR AUTHORIZATION NUMBER

26. FEDERAL TAX ID NUMBER 27. PATIENT'S ACCOUNT NO. 28. ACCEPT ASSIGNMENT? YES NO 29. TOTAL CHARGE \$ 30. AMOUNT PAID \$ 31. PAYEE (NUCC Use)

32. 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.) 33. SERVICE FACILITY LOCATION INFORMATION 34. BILLING PROVIDER INFO & PH# ()

SIGNED DATE 35. NPI 36. NPI 37. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB-0938-1197 FORM 1700102-12 Clear Form

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)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM MM DD YY TO MM DD YY

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	

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		
←		
17a.	×	×
17b.	NPI	

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/2

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

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

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

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. CITY

9. STATE

10. ZIP CODE

11. TELEPHONE (Include Area Code)

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

13. IS PATIENT'S CONDITION RELATED TO

14. INSURED'S POLICY OR GROUP NUMBER

15. EMPLOYMENT? (Current or Previous)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. OUTSIDE LAB?

20. RESUBMISSION CODE

21. PRIOR AUTHORIZATION NUMBER

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

23. OTHER DATE (MM / DD / YY)

24. DATES OF SERVICE (From / To)

25. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances of Service)

26. DIAGNOSIS MONITOR

27. TOTAL CHARGE

28. AMOUNT PAID

29. BILLING PROVIDER INFO & PH#

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials)

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PH#

33. SIGNATURE OF PHYSICIAN OR SUPPLIER

34. DATE

35. NPI

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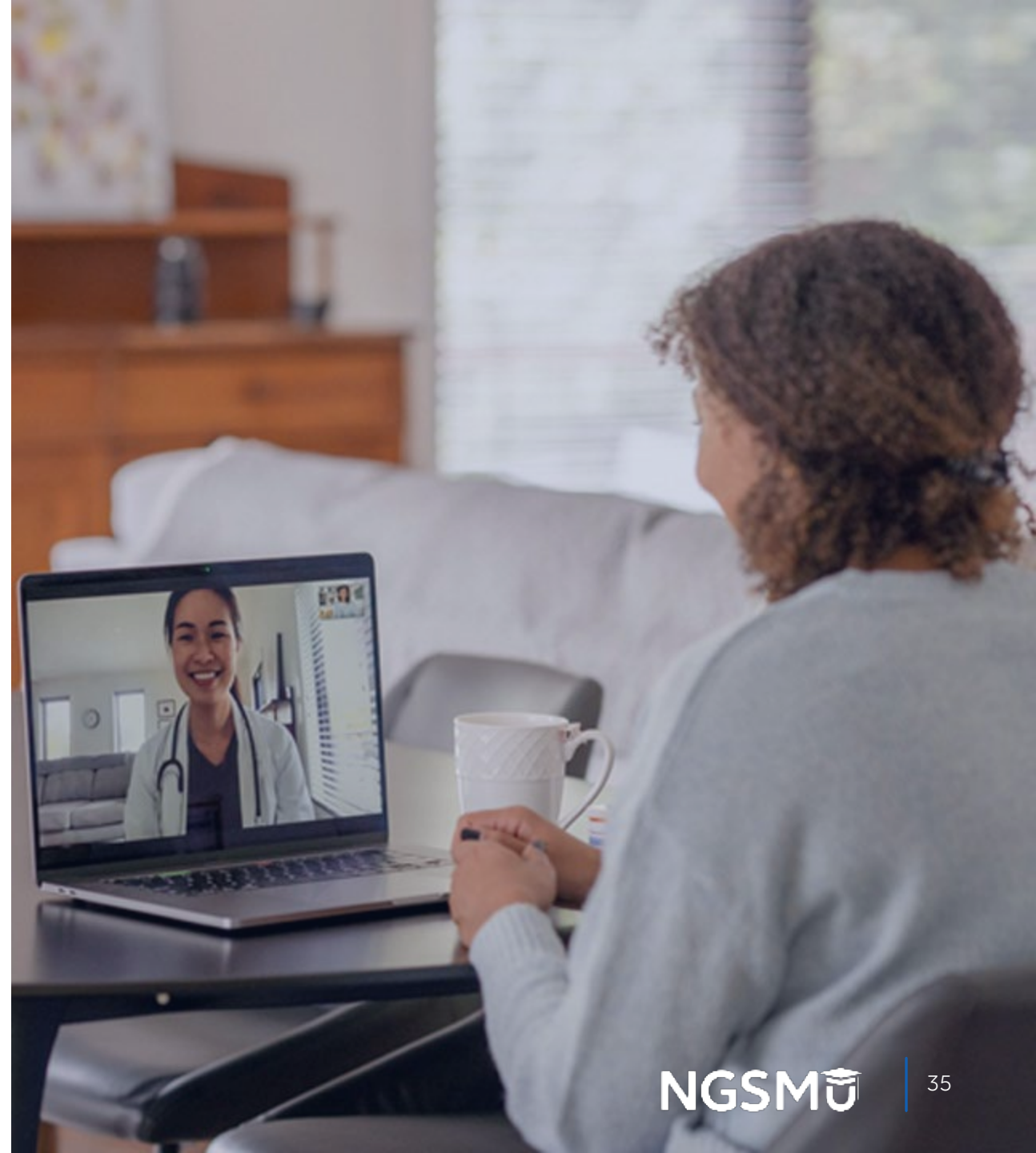
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EMC Equivalent Lines 17 and 17b

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	
			REF02 (1C)		Enter "XX" in the NM108 to indicate an NPI is present in the NM109. Enter the NPI of the referring/ordering physician listed in item 17
			REF02 (1C)	Ordering provider primary ID	



 **HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

☐ PCA ☐ FICA

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHIP/PA ☐ GROUP HEALTH PLAN (GHP) ☐ FECA BOX/CLUB (FCA) ☐ OTHER ☐ 14. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

CITY STATE CITY STATE

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

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (Date) YES NO c. OTHER ACCIDENT? YES NO 10. INSURED'S POLICY GROUP OR FECA NUMBER 11. INSURED'S DATE OF BIRTH MM DD YY SEX M F 12. INSURED'S POLICY GROUP OR FECA NUMBER 13. OTHER CLAIM ID (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 14, and 15

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

18. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) FROM MM DD YY TO MM DD YY 19. OTHER DATE QUAL MM DD YY 20. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 24. OUTSIDE LAST \$ CHARGES YES NO 25. PRIOR AUTHORIZATION NUMBER

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to end of line 24B) ICD-9-CM 27. REVISION CODE ORIGINAL REF. NO. 28. PRIOR AUTHORIZATION NUMBER

29. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DATE OF SERVICE G. DATE OF SERVICE H. DATE OF SERVICE I. DATE OF SERVICE J. RENDERING PROVIDER ID #

30. FEDERAL TAX ID NUMBER 31. PATIENT'S ACCOUNT NO. 32. ACCEPT ASSIGNMENT? YES NO 33. TOTAL CHARGE \$ 34. AMOUNT PAID \$ 35. PROVIDER NUCC USE

36. 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.) 37. SERVICE FACILITY LOCATION INFORMATION 38. BILLING PROVIDER INFO & PH#

SIGNED DATE 39. NPI 40. NPI 41. NPI

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Line Item 18

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

FROM MM DD YY TO MM DD YY

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/22

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐ 1a. INSURED'S I.D. NUMBER (For Programs 1 thru 1)

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

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

CITY STATE CITY STATE

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

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER b. EMPLOYMENT? (Current or Previous) YES NO c. INSURED'S DATE OF BIRTH MM / DD / YY SEX M F

d. RESERVED FOR NUCC USE e. AUTO ACCIDENT? PLACE (Blank) f. OTHER CLAIM ID (Designated by NUCC)

g. RESERVED FOR NUCC USE h. OTHER ACCIDENT? YES NO i. INSURANCE PLAN NAME OR PROGRAM NAME

j. CLAIM CODES (Designated by NUCC) k. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 11, 12, and 13.

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

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 myself or to the party who accepts assignment below.)

SIGNED DATE SIGNED DATE

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

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

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

21. DISPOSITION OR TEST USE OF ILLNESS OR INJURY (State ALL to which the claim applies) ICD-10 CODE

A. B. C. D. E. F. G. H. I. J. K. L. 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. C. D. E. F. G. H. I. J. K. L. 25. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances or Modifiers) 26. DIAGNOSIS MONITOR 27. TOTAL CHARGE \$ 28. AMOUNT PAID \$ 29. Ref. to NUCC Use

1 2 3 4 5 6

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this claim and is made a part thereof.) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PH# ()

SIGNED DATE SIGNED DATE

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Clear Form



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](#)

- 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

20. OUTSIDE LAB?		\$ CHARGES	
<input type="checkbox"/> YES	<input type="checkbox"/> NO		

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. 2400B 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 (NUCC) 02/92

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1. MEDICARE: MEDICAD <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> EDCR BY (UM) <input type="checkbox"/> (CM) <input type="checkbox"/> OTHER <input type="checkbox"/> (CM)										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 <input type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. INSURED'S ADDRESS (St., Street)									
6. PATIENT'S ADDRESS (St., Street)										7. INSURED'S ADDRESS (St., Street)									
8. CITY										9. STATE									
10. ZIP CODE										11. TELEPHONE (Include Area Code)									
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										13. IS PATIENT'S CONDITION RELATED TO:									
14. OTHER INSURED'S POLICY OR GROUP NUMBER										15. EMPLOYMENT (Current or Previous)									
16. RESERVED FOR NUCC USE										17. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)									
18. RESERVED FOR NUCC USE										19. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20. INSURANCE PLAN NAME OR PROGRAM NAME										21. CLAIM CODES (Designated by NUCC)									
READ BACK OF FORM BEFORE COMPLETING AND SENDING. IMPORTANT: 1. 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 myself or to the party who accepts assignment below.																			
SIGNED:										DATE:									
22. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLIMAX (MM) (DD) (YY) QUAL:										23. OTHER DATE (MM) (DD) (YY) QUAL:									
24. NAME OF REFERRING PROVIDER OR OTHER SOURCE										25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM) (DD) (YY)									
26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										27. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: PLEASE SEE INSTRUCTIONS ON REVERSE										29. HOSPITALIZATION CODE									
30. PRIOR AUTHORIZATION NUMBER										31. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM) (DD) (YY) TO (MM) (DD) (YY)									
32. DATES OF SERVICE: From (MM) (DD) (YY) To (MM) (DD) (YY)										33. PROCEDURES, SERVICES OR SUPPLIES (Specify Unusual Circumstances)									
34. A.										35. B.									
36. C.										37. D.									
38. E.										39. F.									
40. G.										41. H.									
42. I.										43. J.									
44. K.										45. L.									
46. FEDERAL TAX I.D. NUMBER										47. PATIENT'S ACCOUNT NO.									
48. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on the reverse applies to the bill and will make a part thereto)										49. SERVICE FACILITY LOCATION INFORMATION									
50. BILLING PROVIDER INFO & Print ()										51. TOTAL CHARGE \$									
52. AMOUNT PAID \$										53. REMAINING BALANCE \$									
54. REMAINING BALANCE \$										55. REMAINING BALANCE \$									

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE ATTACHED CMB-0035-11/97 F.F. 100-102-12

Clear Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHIP/PA (CHIP/PA) <input type="checkbox"/> GROUP HEALTH PLAN (GHP) <input type="checkbox"/> FECA BOX/CUM (FECA BOX/CUM) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. 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)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other)	
7. INSURED'S ADDRESS (No., Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
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? (c) OTHER ACCIDENT?	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment back.)	
13. INSURED'S POLICY GROUP OR FECA NUMBER		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP (MM/DD/YY) QUAL (Qual)	
15. OTHER DATE (MM/DD/YY)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a) (17b) (17c) (17d) (17e) (17f) (17g) (17h) (17i) (17j) (17k) (17l) (17m) (17n) (17o) (17p) (17q) (17r) (17s) (17t) (17u) (17v) (17w) (17x) (17y) (17z)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? (YES/NO) \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L)		22. PRIOR AUTHORIZATION NUMBER	
23. 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.)		24. DATE (MM/DD/YY)	
25. FEDERAL TAX ID NUMBER (SSN/EIN)		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (YES/NO)		28. TOTAL CHARGE \$ AMOUNT PAID \$	
29. 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.)		30. BILLING PROVIDER INFO & PH # ()	

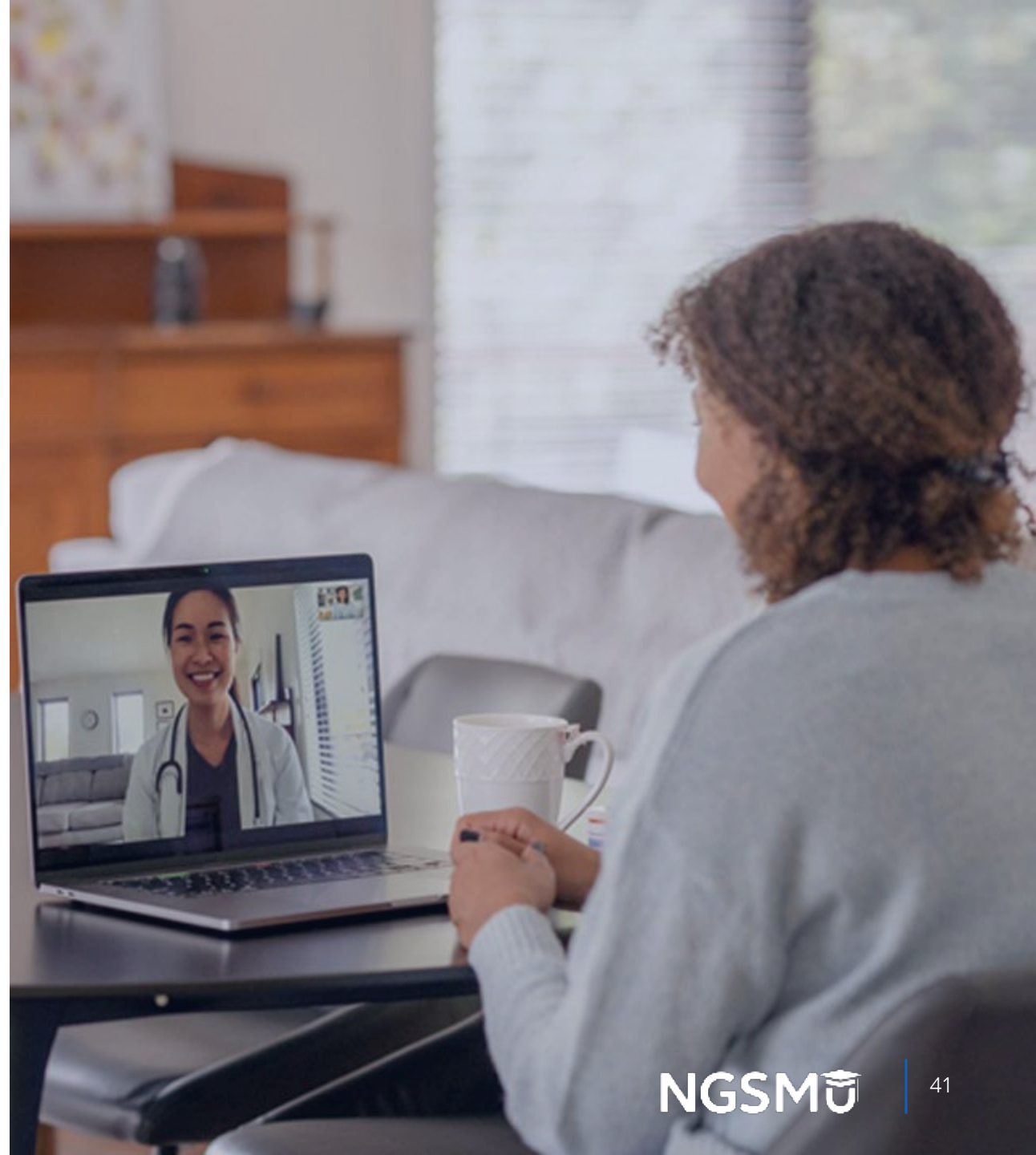
Line Item 21

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.
A.	B.	C.	D.	
E.	F.	G.	H.	
I.	J.	K.	L.	

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](#)



MEDICARE										MEDICAID										TRICARE										CHAMPVA										GROUP HEALTH PLAN										SECA EXCLUDING (OSE)										OTHER																																																											
1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (Member (24)) <input type="checkbox"/> GROUP HEALTH PLAN (GHP) <input type="checkbox"/> SECA EXCLUDING (OSE) <input type="checkbox"/> OTHER (OW) <input type="checkbox"/>										14. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																																													
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5. PATIENT'S ADDRESS (No., Street)																				6. PATIENT RELATIONSHIP TO INSURED Son <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																																																																									
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																				10. IS PATIENT'S CONDITION RELATED TO:																				11. INSURED'S POLICY GROUP OR SECA NUMBER																																																																															
12. OTHER INSURED'S POLICY OR GROUP NUMBER																				a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>																				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. RESERVED FOR NUCC USE																				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)																				b. OTHER CLAIM ID (Designated by NUCC)																																																																															
c. RESERVED FOR NUCC USE																				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																				c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME																				13a. CLAIM CODES (Designated by NUCC)																				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d																																																																															
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</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 request payment of government benefits either to myself or to the party who accepts assignment below.</p>																																								15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier to services described below.																																																																															
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14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) MM DD YY QUAL																				15. OTHER DATE MM DD YY QUAL																				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																				17a. _____																				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				17b. NPI _____																				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A.L. to 10th line below G45) ICD Ed _____																				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																																																																			
A. _____ B. _____ C. _____ D. _____																				23. PRIOR AUTHORIZATION NUMBER _____																																																																																																			
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25. FEDERAL TAX ID NUMBER SSN EIN																				26. PATIENT'S ACCOUNT NO																				27. ACCEPT ASSIGNMENT? (YES/NO/OW) YES <input type="checkbox"/> NO <input type="checkbox"/>																				28. TOTAL CHARGE \$																				29. AMOUNT PAID \$																				30. Ref for NUCC Use																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statements on this form so apply to this bill and are made a part hereof.)																				32. SERVICE FACILITY LOCATION INFORMATION																				33. BILLING PROVIDER INFO & PH# ()																																																																															
SIGNED _____																				DATE _____																				a. NPI _____ b. _____																				a. NPI _____ b. _____																																																											

Line Item 22

- Not required
- | 22. RESUBMISSION
CODE | ORIGINAL REF. NO. |
|--------------------------|-------------------|
| | |
- Not mapped electronically

22. RESUBMISSION CODE	ORIGINAL REF. NO.
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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
- Seven-digit IDE number when investigational device is used in an FDA-approved clinical trial

23. PRIOR AUTHORIZATION NUMBER

[illegible]



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](#)

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](#)

Line Item 25

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

25. FEDERAL TAX ID, NUMBER	SSN EIN
	<input type="text"/> <input type="text"/>

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	

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

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐ 1a. INSURED'S ID NUMBER (For Programs 1-11)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE 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 FCRA 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 myself or to the party who accepts assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 15. OTHER DATE 16. DATES 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 LAB? YES NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in as many as apply) ICD-9-CM 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From To B. C. D. E. F. G. H. I. J. K. L. 25. TOTAL CHARGE \$ 26. AMOUNT PAID \$ 27. BILLING PROVIDER INFO & PH#

28. BILLING PROVIDER INFO & PH# 29. BILLING PROVIDER INFO & PH# 30. BILLING PROVIDER INFO & PH#

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97. BILLING PROVIDER INFO & PH# 98. BILLING PROVIDER INFO & PH# 99. BILLING PROVIDER INFO & PH#

100. BILLING PROVIDER INFO & PH#

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB-0035-11/97 (FORM 1000-102-12)

Clear Form



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GPO/VA HEALTH PLAN (HSA) FECA BOX CLING (FICA) OTHER (For Program in Item 1)

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

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

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

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

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

7. INSURED'S ADDRESS (No., Street)

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to determine ICD-9)

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (From To) B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF SERVICE H. ICD-9 QUAL. J. RENDERING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (To print, check YES or NO)

28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Provider NUCC Use

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. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

34. NPI 35. NPI 36. NPI

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0038-1197 FORM 100102-12

Clear Form

Line Item 26

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

26. PATIENT'S ACCOUNT NO.

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) 02/02

1. MEDICARE MEDICAID TRICARE CHAMPVA OTHER HEALTH PLAN (OHP) RESA BOXING (ROW) OTHER (ROW)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to end of line 24B) ICD-9-CM

22. PRIOR AUTHORIZATION NUMBER

23. REQUESTION CODE ORIGINAL REF. NO.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DATE OF SERVICE G. DATE OF SERVICE H. DATE OF SERVICE I. DATE OF SERVICE J. RENDERING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. PAYEE'S NUCC USE

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. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH#

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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

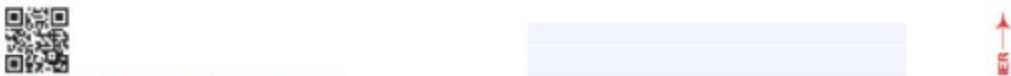
27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)

☐ YES ☐ NO

- 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) 02A2

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE ☐ **MEDICAID** ☐ **TRICARE** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN (GHP)** ☐ **FECA BOXING (FOW)** ☐ **OTHER** ☐

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **5. PATIENT'S ADDRESS** (No., Street) **6. PATIENT RELATIONSHIP TO INSURED** Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) **8. RESERVED FOR NUCC USE**

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **10. IS PATIENT'S CONDITION RELATED TO:** a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO 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. INSURED'S PLAN NAME OR PROGRAM NAME **14. INSURED'S DATE OF BIRTH** MM DD YY **SEX** M F

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **20. OUTSIDE LAB?** ☐ YES ☐ NO **21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** (Read A.L.L. to end of line 24B) ICD-9-CM

22. PRIOR AUTHORIZATION NUMBER **23. RESUBMISSION CODE** **24. A. DATE(S) OF SERVICE** From MM DD YY To MM DD YY **B. PLACE OF SERVICE** **C. PROCEDURES, SERVICES, OR SUPPLIES** (Specify Unusual Circumstances) **D. DIAGNOSIS POINTER** **E. CHARGES** **F. DATE OF SERVICE** **G. DATE OF SERVICE** **H. DATE OF SERVICE** **I. DATE OF SERVICE** **J. RENDERING PROVIDER ID #**

25. FEDERAL TAX ID NUMBER **26. PATIENT'S ACCOUNT NO.** **27. ACCEPT ASSIGNMENT?** (No prior bill, per 401) **28. TOTAL CHARGE** **29. AMOUNT PAID** **30. PROVIDER NUCC USE**

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. SERVICE FACILITY LOCATION INFORMATION** **33. BILLING PROVIDER INFO & PH #**

SIGNED **DATE**

PLEASE PRINT OR TYPE

APPROVED CMB-0938-1197 FORM 1700102-12

Clear Form

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

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.)

SIGNED

DATE

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
	Date signed	N401			

Line Item 32

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

32. SERVICE FACILITY LOCATION INFORMATION	
a. NPI	b.

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Name and address of facility where services were rendered (if other than home or office).	2310C	NM103 (77)	Laboratory or Service Facility Name	NM101 Entity Identifier code=77 - Service Location Required when the location of the service is different than that carried in 2010AA-Billing Provider (Item 32). Enter the name, address city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, and zip code. Required when the location of health care service is different than that carried in the Billing Provider Name (2010AB) loops.
			N301	Laboratory or Service Facility address 1	
			N302	Laboratory or Service Facility address 2	
			N401	Laboratory or Service Facility city	
			N402	Laboratory or Service Facility state	
			N403	Laboratory or Service Facility ZIP code	
		2420C**	NM103 (77)	Laboratory or Service Facility Name	Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address. If an independent laboratory is billing enter the place where the test were performed. Complete this information for all laboratory work performed outside a physician's office. If the service was referred to an outside lab, enter the reference labs name and address. Providers of service must identify the supplier's name, address and NPI when billing for anti-markup tests. If the acquisition provider is out of jurisdiction, you should use the billing provider's NPI. Only bill one unique facility number per claim.
			N301	Laboratory or Service Facility address 1	
			N302	Laboratory or Service Facility address 2	
			N401	Laboratory or Service Facility city	
			N402	Laboratory or Service Facility state	
			N403	Laboratory or Service Facility ZIP code	

Line Items 32 and 32a

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

32. SERVICE FACILITY LOCATION INFORMATION	
a.	NPI

Item No	Claim Description	Loop	Field	Data Element Description	Requirements
32a	NPI	2310C	NM109 (77)	Laboratory/Facility Primary Identifier	Enter the NPI of the Service Facility. Enter "XX" in the NM108 to indicate the NPI is present in the NM109.
		2420C**	NM109 (77)	Laboratory/Facility Primary Identifier	
		2400	PS101	Purchased service provider identifier	
		2420B	NM101	Identification code qualifier =QB	
			NM108	Identification code=XX	
			NM109	Identification code	
			NM101	Identification code qualifier =QB	
32b		2300	NM101	Identification code	
			NM108	Identification code	
			NM109	Identification code	
			REF01	Reference identification qualifier =EV	
			REF02	Mammogram FDA number	
32b		N301			

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/22

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA MILITARY OTHER 1a. INSURED'S I.D. NUMBER (For Programs 1-10)

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

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

8. CITY 9. STATE 10. CITY 11. STATE

12. ZIP CODE 13. TELEPHONE (Include Area Code) 14. ZIP CODE 15. TELEPHONE (Include Area Code)

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

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

22. RESERVED FOR NUCC USE 23. AUTO ACCIDENT? 24. PLACE (Blank) 25. OTHER CLAIM ID (Designated by NUCC)

26. RESERVED FOR NUCC USE 27. OTHER ACCIDENT? 28. INSURANCE PLAN NAME OR PROGRAM NAME

29. INSURANCE PLAN NAME OR PROGRAM NAME 30. CLAIM CODES (Designated by NUCC) 31. IS THERE ANOTHER HEALTH BENEFIT PLAN?

32. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.) 33. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

34. SIGNED DATE 35. SIGNED DATE

36. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY ONSET 37. OTHER DATE 38. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

39. NAME OF REFERRING PROVIDER OR OTHER SOURCE 40. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

41. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 42. OUTSIDE LAB? 43. CHARGER

44. EXAMINER OR NATURE OF ILLNESS OR INJURY (Please fill in to complete bottom of form) 45. ICD-9-CM 46. RESUBMISSION CODE 47. ORIGINAL REF. NO.

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

50. A. DATES OF SERVICE From To B. C. D. E. F. G. H. I. J. K. L. 51. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual, Unusual, Circumstances, Modifiers) 52. DIAGNOSIS MONITOR 53. CHARGES 54. DATE OF BIRTH 55. SEX 56. QUAL 57. RENDERING PROVIDER ID #

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HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA OTHER HEALTH PLAN (OHP) RESA BOX LUNG (ROW) OTHER (ROW)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No. & Street)

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MMP)

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to determine both ICD and ICD-9)

22. PRIOR AUTHORIZATION NUMBER

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

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Diagnose Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DATE OF SERVICE G. DATE OF SERVICE H. DATE OF SERVICE I. DATE OF SERVICE J. RENDERING PROVIDER ID #

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

31. BILLING PROVIDER INFO & PH # ()

32. BILLING PROVIDER INFO & PH # ()

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

33. BILLING PROVIDER INFO & PH # ()

A. NPI B.

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 (B5)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
			NM104	Provider first name	NM101 Entity Identifier=87-Pay-to-provider
			NM105	Provider middle initial	
			N301	Provider address 1	NM102 Entity Type code 1 Person 2 Non-Person Entity
			N401	Provider city	
			N402	Provider state	Enter the provider or service/supplier's billing name, address, zip code and telephone number. Must be a physical address with nine-digit ZIP code.
			N403	Provider ZIP code	
			PER04	Provider phone number	
33a	NPI	2010AA	NM109 (B5)	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
33b	Billing Taxonomy Number	2000A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PXC

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims					
The information contained in this crosswalk is for reference purposes only.					
* = If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.					
** = Use if different than information given at the claim level. 7/6/2012 - KJT 1					
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary)
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)
2	Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card
			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr. Sr.)	
3	Patient's Birth Date and gender	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8
			DMG03	Gender	
4*	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	



Claim Rejection Reminders

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

Resources and References

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

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.



medicare **mobile**
Text NEWS to 37702; Text GAMES to 37702

