

Proper Part B Claim Submissions

6/25/2025

Closed Captioning: Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.



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Today's Presenters

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Dunphy, CPC

Provider Outreach and
Education Consultant



Carleen
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Provider Outreach and
Education Consultant





Recording

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

Objective

After completion attendees will be able to

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



Agenda

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

Claim Form Requirements

Claim Submission Requirements

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



ASCA Regulations

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

Time Limits for Filing Medicare Claims

Claim Filing Time Limits

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



Claim Form Overview

CMS-1500 Claim Form (02/12)

Beneficiary data →

Provider data →

The form is titled "HEALTH INSURANCE CLAIM FORM" and includes a QR code in the top left corner. It is divided into three main sections: "PATIENT AND INSURANCE INFORMATION" (top), "PATIENT AND PROVIDER INFORMATION" (middle), and "PATIENT AND PROVIDER INFORMATION" (bottom). The "Beneficiary data" label points to the top section, and the "Provider data" label points to the middle section. A red horizontal line separates the top and middle sections.



NUCC Approved OMB

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

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

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

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

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

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

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

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

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

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

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

25. OTHER INSURED'S POLICY OR GROUP NUMBER **26. EMPLOYMENT (Current or Previous)** **27. AUTO-ACCIDENT** **28. OTHER ACCIDENT** **29. IS THERE ANOTHER HEALTH BENEFIT PLAN?**

30. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) **31. OTHER DATE** **32. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

33. NAME OF REFERRING PROVIDER OR OTHER SOURCE **34. HOSPITALIZATION DATE** **35. OUTSIDE CASE** **36. REBATE/REASON CODE** **37. PRIOR AUTHORIZATION NUMBER**

38. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY **39. PROCEDURE, SERVICE, or SUPPLY** **40. CHARGES** **41. DAYS OF LOS** **42. H. P. N. QUAL** **43. RENDERING PROVIDER ID #**

44. SIGNATURE OF PHYSICIAN OR SUPPLIER **45. SERVICE FACILITY LOCATION INFORMATION** **46. BILLING PROVIDER INFO & PH #**

47. SIGNATURE OF PHYSICIAN OR SUPPLIER **48. DATE** **49. PATIENT'S ACCOUNT NO.** **50. ACCEPT ASSIGNMENT?** **51. TOTAL CHARGE** **52. AMOUNT PAID** **53. BALANCE DUE**

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712. SIGNATURE OF PHYSICIAN OR SUPPLIER **713. DATE** **714. PATIENT'S ACCOUNT NO.** **715. ACCEPT ASSIGNMENT?** **716. TOTAL CHARGE** **717. AMOUNT PAID** **718. BALANCE DUE**

719. SIGNATURE OF PHYSICIAN OR SUPPLIER **720. DATE** **721. PATIENT'S ACCOUNT NO.** **722. ACCEPT ASSIGNMENT?** **723. TOTAL CHARGE** **724. AMOUNT PAID** **725. BALANCE DUE**

726. SIGNATURE OF PHYSICIAN OR SUPPLIER **727. DATE** **728. PATIENT'S ACCOUNT NO.** **729. ACCEPT ASSIGNMENT?** **730. TOTAL CHARGE** **731. AMOUNT PAID** **732. BALANCE DUE**

733. SIGNATURE OF PHYSICIAN OR SUPPLIER **734. DATE** **735. PATIENT'S ACCOUNT NO.** **736. ACCEPT ASSIGNMENT?** **737. TOTAL CHARGE** **738. AMOUNT PAID** **739. BALANCE DUE**

740. SIGNATURE OF PHYSICIAN OR SUPPLIER **741. DATE** **742. PATIENT'S ACCOUNT NO.** **743. ACCEPT ASSIGNMENT?** **744. TOTAL CHARGE** **745. AMOUNT PAID** **746. BALANCE DUE**

747. SIGNATURE OF PHYSICIAN OR SUPPLIER **748. DATE** **749. PATIENT'S ACCOUNT NO.** **750. ACCEPT ASSIGNMENT?** **751. TOTAL CHARGE** **752. AMOUNT PAID** **753. BALANCE DUE**

754. SIGNATURE OF PHYSICIAN OR SUPPLIER **755. DATE** **756. PATIENT'S ACCOUNT NO.** **757. ACCEPT ASSIGNMENT?** **758. TOTAL CHARGE** **759. AMOUNT PAID** **760. BALANCE DUE**

761. SIGNATURE OF PHYSICIAN OR SUPPLIER **762. DATE** **763. PATIENT'S ACCOUNT NO.** **764. ACCEPT ASSIGNMENT?** **765. TOTAL CHARGE** **766. AMOUNT PAID** **767. BALANCE DUE**

768. SIGNATURE OF PHYSICIAN OR SUPPLIER **769. DATE** **770. PATIENT'S ACCOUNT NO.** **771. ACCEPT ASSIGNMENT?** **772. TOTAL CHARGE** **773. AMOUNT PAID** **774. BALANCE DUE**

775. SIGNATURE OF PHYSICIAN OR SUPPLIER **776. DATE** **777. PATIENT'S ACCOUNT NO.** **778. ACCEPT ASSIGNMENT?** **779. TOTAL CHARGE** **780. AMOUNT PAID** **781. BALANCE DUE**

782. SIGNATURE OF PHYSICIAN OR SUPPLIER **783. DATE** **784. PATIENT'S ACCOUNT NO.** **785. ACCEPT ASSIGNMENT?** **786. TOTAL CHARGE** **787. AMOUNT PAID** **788. BALANCE DUE**

789. SIGNATURE OF PHYSICIAN OR SUPPLIER **790. DATE** **791. PATIENT'S ACCOUNT NO.** **792. ACCEPT ASSIGNMENT?** **793. TOTAL CHARGE** **794. AMOUNT PAID** **795. BALANCE DUE**

796. SIGNATURE OF PHYSICIAN OR SUPPLIER **797. DATE** **798. PATIENT'S ACCOUNT NO.** **799. ACCEPT ASSIGNMENT?** **800. TOTAL CHARGE** **801. AMOUNT PAID** **802. BALANCE DUE**

803. SIGNATURE OF PHYSICIAN OR SUPPLIER **804. DATE** **805. PATIENT'S ACCOUNT NO.** **806. ACCEPT ASSIGNMENT?** **807. TOTAL CHARGE** **808. AMOUNT PAID** **809. BALANCE DUE**

810. SIGNATURE OF PHYSICIAN OR SUPPLIER **811. DATE** **812. PAT**

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

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

5. PATIENT'S ADDRESS (incl. Street)
 CITY STATE ZIP CODE TELEPHONE (include Area Code)

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

7. INSURED'S ADDRESS (incl. Street)
 CITY STATE ZIP CODE TELEPHONE (include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
9. OTHER INSURED'S POLICY OR GROUP NUMBER
10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT (Current or Previous) ☐ YES ☐ NO
 b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
 c. OTHER ACCIDENT? ☐ YES ☐ NO
11. INSURED'S POLICY GROUP OR FECA NUMBER
 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?
☐ YES ☐ NO If yes, complete below: YES, NO, YES, NO
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
 SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
 SIGNED
14. DATE OF CURRENT SURGERY, INJURY, OR PREGNANCY DATE QUAL. MM DD YY
15. OTHER DATE QUAL. MM DD YY
16. DATE WHEN PATIENT BECAME UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN 17a NR
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTPATIENT CHARGES ☐ YES ☐ NO ☐ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Provide ALL information below: ICD-9-CM
 A. B. C. D.
 E. F. G. H.
 I. J. K. L.
22. PHYSICIAN OR SUPPLIER INFORMATION
 A. DATE OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE ☐ HOME ☐ OFFICE ☐ OTHER ☐ C. PROVIDER'S NAME (Last, First, Middle Initial) D. PROVIDER'S ADDRESS (Street, City, State, ZIP Code) E. PROVIDER'S PHONE NUMBER
 F. CHARGES G. DATE OF SERVICE H. PLACE OF SERVICE I. PROVIDER'S NAME J. PROVIDER'S ADDRESS K. PROVIDER'S PHONE NUMBER
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE OF SERVICE From MM DD YY To MM DD YY **B. PLACE OF SERVICE** ☐ HOME ☐ OFFICE ☐ OTHER ☐ **C. PROVIDER'S NAME** (Last, First, Middle Initial) **D. PROVIDER'S ADDRESS** (Street, City, State, ZIP Code) **E. PROVIDER'S PHONE NUMBER**
25. FEDERAL TAX ID NUMBER SSN SSN **26. PATIENT'S ACCOUNT NO.** **27. ACCEPT ASSIGNMENT?** YES ☐ NO ☐ **28. TOTAL CHARGE** \$ **29. AMOUNT PAID** \$ **30. FEES BY NUCC USE**
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials. If both, the initials to be the owner apply to the 31 and not to the part below.) **32. SERVICE FACILITY LOCATION INFORMATION** **33. BILLING PROVIDER INFO & Print** ()

Line Item 1

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

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

Line Item 1a

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

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

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

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

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA SECONDARY HEALTH PLAN (N/A) (N/A) (N/A) (N/A) (N/A) (N/A)

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

3. PATIENT'S ADDRESS (No. Street) (N/A) (N/A) (N/A)

4. CITY (N/A) STATE (N/A) ZIP CODE (N/A)

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

6. OTHER INSURED'S POLICY OR GROUP NUMBER (N/A)

7. INSURED'S ADDRESS (No. Street) (N/A) (N/A) (N/A)

8. CITY (N/A) STATE (N/A) ZIP CODE (N/A)

9. INSURED'S POLICY OR GROUP OR FECA NUMBER (N/A)

10. INSURED'S DATE OF BIRTH (MM/DD/YY) (N/A) (N/A) (N/A)

11. OTHER CLAIM TO DATE (N/A)

12. INSURANCE PLAN NAME OR PROGRAM NAME (N/A)

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? (N/A)

14. DATE OF CURRENT SURGERY, INJURY, OR FREQUENTLY LABELED (N/A)

15. OTHER DATE (N/A)

16. DATE OF SURGERY, INJURY, OR FREQUENTLY LABELED (N/A)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (N/A)

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (N/A)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) (N/A)

20. OUTSIDE LAB? (N/A)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (N/A)

22. HMBLATION CODE (N/A)

23. PRIOR AUTHORIZATION NUMBER (N/A)

24. A. DATE OF SERVICE (N/A) B. PLACE OF SERVICE (N/A) C. PROCEDURE, SUPPLY, OR SUPPLY (N/A) D. DIAGNOSIS (N/A) E. CHARGE (N/A) F. AMOUNT PAID (N/A) G. REVENUE (N/A)

25. FEDERAL TAX ID NUMBER (N/A)

26. PATIENT'S ACCOUNT NO. (N/A)

27. ACCOUNT ASSIGNMENT? (N/A)

28. TOTAL CHARGE (N/A)

29. AMOUNT PAID (N/A)

30. REVENUE (N/A)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (N/A)

32. SERVICE FACILITY LOCATION INFORMATION (N/A)

33. BILLING PROVIDER INFO & PH# (N/A)

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

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

4. PATIENT'S ADDRESS (No. Street)

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

6. RESERVED FOR NUCC USE

7. RESERVED FOR NUCC USE

8. RESERVED FOR NUCC USE

9. RESERVED FOR NUCC USE

10. RESERVED FOR NUCC USE

11. RESERVED FOR NUCC USE

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

13. INSURED'S POLICY OR GROUP OR FOSA NUMBER

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

15. OTHER CLAIM ID (Designated by NUCC)

16. INSURANCE PLAN NAME OR PROGRAM NAME

17. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) (If yes, complete items 18, 19, and 20)

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

19. HOSPITALIZATION DATES (FROM TO)

20. OUTSIDE LAB? (YES NO) \$ CHARGES

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

22. PHYSICIAN OR SUPPLIER'S SIGNATURE (I certify that the information on this cover is true and correct and is a part of my record.)

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (CPT/HCPCS) C. PROCEDURE, SERVICE, OR SUPPLY (CPT/HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGE (ICD-9-CM) F. AMOUNT PAID (ICD-9-CM) G. PAYMENT METHOD (ICD-9-CM)

25. FEDERAL TAX ID NUMBER SIGN SIGN

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 (INCLUDES DEGREE OR CREDENTIALS (I certify that the information on this cover is true and correct and is a part of my record.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

Line Item 2

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

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

- 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												PATIENT AND INSURED INFORMATION
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) (02/82)												
☐ MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHIPRA ☐ GROUP HEALTH PLAN ☐ SELF OR BOX COVERED ☐ OTHER												
1. PATIENT'S NAME (Last name, First name, Middle initial)												INSURED'S ID NUMBER (For Program in Item 1)
2. PATIENT'S ADDRESS (No. Street)												INSURED'S NAME (Last name, First name, Middle initial)
3. PATIENT'S BIRTH DATE MM / DD / YY M F												INSURED'S ADDRESS (No. Street)
CITY	STATE	4. RESERVED FOR NUCC USE				CITY	STATE					
ZIP CODE	TELEPHONE (include Area Code)					ZIP CODE	TELEPHONE (include Area Code)					
5. OTHER INSURED'S NAME (Last name, First name, Middle initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY OR GROUP OR FEDCA NUMBER				
6. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO				a. INSURED'S DATE OF BIRTH MM / DD / YY SEX M F				
5. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)				b. OTHER CLAIM ID (Date granted by NUCC)				
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? ☐ YES ☐ NO				c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME				10g. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete item 9, 10, and 11.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. 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.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below.
WOUND _____ DATE _____												SIGNED _____
14. DATA ON CURRENT SURVIVAL, INJURY, or PREGNANCY (Gestational weeks, days, hours, minutes, seconds)						15. OTHER DATE QUAL. MM / DD / YY			16. DATE PATIENT WANTS TO WORK IN CURRENT OCCUPATION FROM MM / DD / YY TO MM / DD / YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN _____ TIN _____									18. HOSPITALIZATION DATES RELATIVE TO CURRENT SERVICES FROM MM / DD / YY TO MM / DD / YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTPATIENT? ☐ YES ☐ NO \$ CHARGE
21. DIAGNOSIS OR NATURE OF LOSS OF INCURRED (Provide ALL in verbatim below ICD-9-CM) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												22. PRESCRIPTION CODE ORIGINAL RFP NO. _____
24. A. DATES OF SERVICE From MM / DD / YY To MM / DD / YY B. PLACE OF SERVICE EMS C. PROCEDURE, SUPPLY, OR SUPPLIER (Origin Unk, Orig, Other) DRUG/RX E. DIAGNOSIS POSITION F. \$ CHARGE G. SHIP PER WEEK H. WHOLESALE PRICE I. ID QUANTITY J. NONCERING 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. BILLING PROVIDER INFO & PH# ()
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CERTIFICATION (I certify that this statement is true except as noted.)												32. SERVICE FACILITY LOCATION INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION												

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR MUCC USE

11. RESERVED FOR MUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

20. OUTSIDE LAMP

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide AC, E, or ICD-9-CM code)

22. PHYSICIAN OR SUPPLIER INFORMATION

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. CREDIT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. RESERVE MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (I certify that the claimant is or has control apply to this bill and can receive a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

Line Item 4

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

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

Line Item 5

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

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

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/00/02/02

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

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. INSURED'S POLICY OR GROUP OR FICA NUMBER

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

8. OTHER CLAIM ID (Designated by NCCI)

9. IS THERE ANOTHER HEALTH BENEFIT PLAN?

10. EMPLOYMENT (Current or Former)

11. AUTO ACCIDENT?

12. OTHER ACCIDENT?

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

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

15. OTHER DATE (MM/DD/YY)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

19. OUTSIDE LAB?

20. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL, even if not below ICD-9-CM)

22. ICD-9-CM CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (English, Unabbreviated, or CPT/HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. INPATIENT OR OUTPATIENT G. INPATIENT OR OUTPATIENT H. INPATIENT OR OUTPATIENT I. INPATIENT OR OUTPATIENT J. INPATIENT OR OUTPATIENT

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. REMAINING BALANCE

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

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & P#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

3. PATIENT'S ADDRESS (No. Street)

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

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

6. OTHER INSURED'S POLICY OR GROUP NUMBER

7. RESERVED FOR MUCC USE

8. RESERVED FOR MUCC USE

9. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PRESENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR POLICY NUMBER

12. INSURED'S DATE OF BIRTH SEX

13. OTHER CLAIMS (Designated by MUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN?

16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be assigned to the party who accepts assigned below)

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

18. OTHER DATE

19. DATE WHEN PATIENT BECAME UNABLE TO WORK IN CURRENT OCCUPATION

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

21. OUTSIDE LAMP

22. PHYSICIAN CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO PLACE OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 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. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address or credentials) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Item 6

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

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

Line Item 7

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

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

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

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

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO (See Instructions) 10. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES, NO) (If yes, complete Item 9, 10, and 11)

11. EMPLOYMENT (Current or Former) 12. AUTO ACCIDENT? (YES, NO) 13. OTHER ACCIDENT? (YES, NO) 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES, NO) (If yes, complete Item 9, 10, and 11)

15. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F) 16. OTHER CLAIM ID (See Instructions) 17. INSURANCE PLAN NAME OR PROGRAM NAME 18. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES, NO) (If yes, complete Item 9, 10, and 11)

19. 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 after to report to the party who accepts assignment below.) 20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.)

21. DATE OF CURRENT SURGERY, INJURY, OR PHYSICIAN'S CLAIM (MM, DD, YY) 22. OTHER DATE (MM, DD, YY) 23. DATE OF BIRTH (MM, DD, YY) 24. DATE OF BIRTH (MM, DD, YY) 25. DATE OF BIRTH (MM, DD, YY) 26. DATE OF BIRTH (MM, DD, YY) 27. DATE OF BIRTH (MM, DD, YY) 28. DATE OF BIRTH (MM, DD, YY) 29. DATE OF BIRTH (MM, DD, YY) 30. DATE OF BIRTH (MM, DD, YY) 31. DATE OF BIRTH (MM, DD, YY) 32. DATE OF BIRTH (MM, DD, YY) 33. DATE OF BIRTH (MM, DD, YY) 34. DATE OF BIRTH (MM, DD, YY) 35. DATE OF BIRTH (MM, DD, YY) 36. DATE OF BIRTH (MM, DD, YY) 37. DATE OF BIRTH (MM, DD, YY) 38. DATE OF BIRTH (MM, DD, YY) 39. DATE OF BIRTH (MM, DD, YY) 40. DATE OF BIRTH (MM, DD, YY) 41. DATE OF BIRTH (MM, DD, YY) 42. DATE OF BIRTH (MM, DD, YY) 43. DATE OF BIRTH (MM, DD, YY) 44. DATE OF BIRTH (MM, DD, YY) 45. DATE OF BIRTH (MM, DD, YY) 46. DATE OF BIRTH (MM, DD, YY) 47. DATE OF BIRTH (MM, DD, YY) 48. DATE OF BIRTH (MM, DD, YY) 49. DATE OF BIRTH (MM, DD, YY) 50. DATE OF BIRTH (MM, DD, YY) 51. DATE OF BIRTH (MM, DD, YY) 52. DATE OF BIRTH (MM, DD, YY) 53. DATE OF BIRTH (MM, DD, YY) 54. DATE OF BIRTH (MM, DD, YY) 55. DATE OF BIRTH (MM, DD, YY) 56. DATE OF BIRTH (MM, DD, YY) 57. DATE OF BIRTH (MM, DD, YY) 58. DATE OF BIRTH (MM, DD, YY) 59. DATE OF BIRTH (MM, DD, YY) 60. DATE OF BIRTH (MM, DD, YY) 61. DATE OF BIRTH (MM, DD, YY) 62. DATE OF BIRTH (MM, DD, YY) 63. DATE OF BIRTH (MM, DD, YY) 64. DATE OF BIRTH (MM, DD, YY) 65. DATE OF BIRTH (MM, DD, YY) 66. DATE OF BIRTH (MM, DD, YY) 67. DATE OF BIRTH (MM, DD, YY) 68. DATE OF BIRTH (MM, DD, YY) 69. DATE OF BIRTH (MM, DD, YY) 70. DATE OF BIRTH (MM, DD, YY) 71. DATE OF BIRTH (MM, DD, YY) 72. DATE OF BIRTH (MM, DD, YY) 73. DATE OF BIRTH (MM, DD, YY) 74. DATE OF BIRTH (MM, DD, YY) 75. DATE OF BIRTH (MM, DD, YY) 76. DATE OF BIRTH (MM, DD, YY) 77. DATE OF BIRTH (MM, DD, YY) 78. DATE OF BIRTH (MM, DD, YY) 79. DATE OF BIRTH (MM, DD, YY) 80. DATE OF BIRTH (MM, DD, YY) 81. DATE OF BIRTH (MM, DD, YY) 82. DATE OF BIRTH (MM, DD, YY) 83. DATE OF BIRTH (MM, DD, YY) 84. DATE OF BIRTH (MM, DD, YY) 85. DATE OF BIRTH (MM, DD, YY) 86. DATE OF BIRTH (MM, DD, YY) 87. DATE OF BIRTH (MM, DD, YY) 88. DATE OF BIRTH (MM, DD, YY) 89. DATE OF BIRTH (MM, DD, YY) 90. DATE OF BIRTH (MM, DD, YY) 91. DATE OF BIRTH (MM, DD, YY) 92. DATE OF BIRTH (MM, DD, YY) 93. DATE OF BIRTH (MM, DD, YY) 94. DATE OF BIRTH (MM, DD, YY) 95. DATE OF BIRTH (MM, DD, YY) 96. DATE OF BIRTH (MM, DD, YY) 97. DATE OF BIRTH (MM, DD, YY) 98. DATE OF BIRTH (MM, DD, YY) 99. DATE OF BIRTH (MM, DD, YY) 100. DATE OF BIRTH (MM, DD, YY)

PATIENT AND INSURED INFORMATION									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN ISCA RY (LINE) OTHER ☐ MEDICAID ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ ISCA RY (LINE) ☐ OTHER					1a. INSURED'S ID NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
3. PATIENT'S ADDRESS (No. Street)					7. INSURED'S ADDRESS (No. Street)				
CITY					STATE				
ZIP CODE					TELEPHONE (Include Area Code)				
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					8. INSURED'S POLICY GROUP OR POLA NUMBER				
9. OTHER INSURED'S POLICY OR GROUP NUMBER					9. INSURED'S DATE OF BIRTH (MM DD YY) SEX				
10. RESERVED FOR NUCC USE					10. OTHER CLAIM ID (Designated by NUCC)				
11. RESERVED FOR NUCC USE					11. INSURANCE PLAN NAME OR PROGRAM NAME				
12. RESERVED FOR NUCC USE					12. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
13. INSURANCE PLAN NAME OR PROGRAM NAME					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 provisions benefits other to myself or to the party who accepts assignment below.)				
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (Last)					15. DATE OF BIRTH (Last)				
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					19. OUTSIDE LAB? ☐ YES ☐ NO				
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL from list below. Do not check more than one.)					21. REFERRAL OR ORDER				
22. A. DATE OF SERVICE FROM TO YEAR MONTH DAY					23. PRIOR AUTHORIZATION NUMBER				
24. B. PLACE OF SERVICE (Indicate Universal Designated Code)					25. REFERRING PROVIDER'S ID #				
26. C. PROCEDURE, SERVICE, OR SUPPLY (Indicate Universal Designated Code)					27. TOTAL CHARGE				
28. D. DIAGNOSIS (Indicate Universal Designated Code)					29. AMOUNT PAID				
29. FEDERAL TAX ID NUMBER					30. SERVICE FACILITY LOCATION INFORMATION				
30. PATIENT'S ACCOUNT NO.					31. BILLING PROVIDER INFO (Print #)				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include designation of credentials. I certify that the statement on this invoice applies to this bill and on all bills a part thereof.)					32. BILLING PROVIDER INFO (Print #)				

Line Item 8

- Reserved for future NUCC use
- Not mapped electronically

Line Items 9, 9a–9d

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

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

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

11. INSURED'S POLICY OR GROUP OR FECA NUMBER

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

13. INSURED'S SEX (M/F)

14. OTHER CLAIM ID (Date granted by NUCC)

15. INSURANCE PLAN NAME OR PROGRAM NAME

16. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

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

19. NAME OF REFERRING PROVIDER OR OTHER SOURCE

20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, Event/Injury below ICD-9)

22. PHYSICIAN CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLEMENTAL (Specify Unlicensed, Licensed, or Other) D. DIAGNOSIS (ICD-9-CM) E. CHARGE F. CHARGE G. CHARGE H. CHARGE I. CHARGE J. CHARGE K. CHARGE L. CHARGE M. CHARGE N. CHARGE O. CHARGE P. CHARGE Q. CHARGE R. CHARGE S. CHARGE T. CHARGE U. CHARGE V. CHARGE W. CHARGE X. CHARGE Y. CHARGE Z. CHARGE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE

29. ACCOUNT PAID

30. PROVIDER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if any; that the undersigned is a provider apply to the SE and use under a paid benefit)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PIN#

EMC Equivalent Lines 9, 9a–9d

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

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

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GOVT HEALTH PLAN OTHER (100) (100) (100) (100) (100)

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

3. PATIENT'S ADDRESS (incl. Street)

4. CITY

5. STATE

6. ZIP CODE

7. PATIENT'S RELATIONSHIP TO INSURED

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

9. INSURED'S ADDRESS (incl. Street)

10. CITY

11. STATE

12. ZIP CODE

13. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

b. AUTO ACCIDENT? PLACE (State)

c. OTHER ACCIDENT?

14. INSURED'S POLICY GROUP OR PROGRAM NUMBER

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

16. SEX (M/F)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include all, use descriptive below)

20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

21. OUTSIDE LAB?

22. PRIOR AUTHORIZATION NUMBER

23. SIGNATURE OF PATIENT OR SUPPLIER

24. SERVICE FACILITY LOCATION INFORMATION

25. BILLING PROVIDER INFO & Pmt #

Line Items 10a, 10b and 10c

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

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

Line Item 10d

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

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

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

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

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

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

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

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

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

18. RESUBMITTED FOR NUCC USE 19. OTHER ACCIDENT? (See Instructions) 20. INSURANCE PLAN NAME OR PROGRAM NAME

21. INSURANCE PLAN NAME OR PROGRAM NAME 22. CLAIM CODES (Designated by NUCC) 23. ANOTHER HEALTH BENEFIT PLAN? (See Instructions)

24. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (To process this claim, I also request payment of government contribution to be input or to the party who accepts assignment below) 25. DATE 26. SIGNED

27. DATE OF CURRENT SURGERY, INJURY, OR PREVIOUSLY CLAIMED 28. OTHER DATE 29. DATE OF LAST WORK IN CURRENT OCCUPATION

30. NAME OF REFERRING PROVIDER OR OTHER SOURCE 31. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

32. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 33. OUTSIDE LAB? (See Instructions)

34. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all, even inactive below ICD-9-CM) 35. PHYSICIAN OR SUPPLIER INFORMATION

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

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials (I certify that this statement or its contents apply to this claim and are made in good faith)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & Print ()

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

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

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

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

11. INSURED'S POLICY OR GROUP NUMBER

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be made to the party who accepts assigned claims.

13. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUS CLAIM 14. OTHER DATE 15. DATE OF BIRTH (MM DD YY) 16. DATE OF BIRTH (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, even those below 21d) 22. PHYSICIAN OR SUPPLIER INFORMATION 23. PRIOR AUTHORIZATION NUMBER 24. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. CREDIT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. PAYEE'S NAME 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ()

Line Items 11, 11a–11d

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

EMC Equivalent Line 11, 11a–11c

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
11*	Insured policy group or FECA number	2320 or 2000B	SBR01	Payer responsibility P = Primary S = Secondary T = Tertiary *Note: If Medicare is Primary, use letter "P" and skip to item 12.	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to potentially be involved in paying this claim.
		2320	SBR03	Insured Group or Policy Number	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	
			NM109	Insured's identifier	
		2000B or 2320	SBR05	Insurance Type Code	
				Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"	
		2300	CLM01	Claim submitter's identifier	
			CLM02	Monetary amount	
		2320	AMT01	Amount qualifier code = D	
			AMT02	Monetary amount (Primary Paid Claim Level)	
		2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)	
			CAS02	Claim adjustment reason codes	
			CAS03	Adjustment amount	
			CAS04	Adjustment quantity	
		2330B or 2430	DTP01	Primary insurance adjudication date	
			DTP02	Date time period qualifier	
			DTP03	Date paid	

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

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

Line Item 12

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

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

HEALTH INSURANCE CLAIM FORM

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

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY OR GROUP OR FICA NUMBER

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

13. DATE

14. SIGNED

15. DATE

16. SIGNED

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDRESS

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, if verbatim below ICD-9-CM)

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

22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

23. OUTSIDE LAB?

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

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCOUNT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BILLING PROVIDER INFO & PH#

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials (If entity that the signature is the owner, apply to the SE and use inside a paid format))

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

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

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

11. ZIP CODE TELEPHONE (Include Area Code) 12. ZIP CODE TELEPHONE (Include Area Code)

13. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 14. IS PRESENT CONDITION RELATED TO (a. EMPLOYMENT (Current or Former) b. AUTO ACCIDENT? c. OTHER CLAIMS? (Designated by MUCC))

15. OTHER INSURED'S POLICY OR GROUP NUMBER 16. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)

17. RESERVED FOR MUCC USE 18. AUTO ACCIDENT? (a. EMPLOYMENT (Current or Former) b. AUTO ACCIDENT? c. OTHER CLAIMS? (Designated by MUCC))

19. RESERVED FOR MUCC USE 20. OTHER ACCIDENT? (a. EMPLOYMENT (Current or Former) b. AUTO ACCIDENT? c. OTHER CLAIMS? (Designated by MUCC))

21. INSURANCE PLAN NAME OR PROGRAM NAME 22. IS THERE ANOTHER HEALTH BENEFIT PLAN? (a. YES b. NO)

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

24. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICALLY CLAMS (MM/DD/YY) 25. OTHER DATE (MM/DD/YY)

26. NAME OF REFERRING PROVIDER OR OTHER SOURCE 27. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO)

28. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 29. OUTSIDE LAMP (a. YES b. NO) c. CHARGE

30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9 code below) 31. PHYSICIAN OR SUPPLIER INFORMATION (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

32. A. CARRIER OF SERVICE (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER) 33. B. PROCEDURE, SERVICE, OR SUPPLY (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

34. C. DATE OF SERVICE (a. FROM b. TO c. PLACE OF SERVICE) 35. D. CHARGE (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

36. E. TOTAL CHARGE (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER) 37. F. AMOUNT PAID (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

38. G. PATIENT'S ACCOUNT NO. 39. H. ACCOUNT ASSIGNMENT (a. YES b. NO) 40. I. TOTAL CHARGE (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

41. J. SIGNATURE OF PHYSICIAN OR SUPPLIER (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER) 42. K. SERVICE FACILITY LOCATION INFORMATION (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

43. L. BILLING PROVIDER INFO & PAY (a. NAME b. ADDRESS c. PHONE d. FAX e. EMAIL f. OTHER)

Line Item 13

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

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

Line Item 14

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

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

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

PCIA ☐ PICA ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ SELF-EMPLOYED ☐ OTHER ☐

2. PATIENT'S NAME (Last name, first name, middle initial)
3. PATIENT'S ADDRESS (No. Street)
CITY STATE ZIP CODE TELEPHONE (include Area Code)

4. PATIENT'S BIRTH DATE MM DD YY SEX M F
5. PATIENT RELATIONSHIP TO INSURED
6. RESERVED FOR MUCC USE
7. INSURED'S NAME (Last name, first name, middle initial)
8. INSURED'S ADDRESS (No. Street)
CITY STATE ZIP CODE TELEPHONE (include Area Code)

9. OTHER INSURED'S NAME (Last name, first name, middle initial)
10. OTHER INSURED'S POLICY OR GROUP NUMBER
11. INSURED'S POLICY OR GROUP OR PICA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)
13. INSURED'S DATE OF BIRTH MM DD YY SEX M F
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. INSURED'S DATE OF BIRTH MM DD YY SEX M F
16. DATE OF PATIENT'S PREVIOUS OCCUPATION TO CURRENT OCCUPATION FROM TO MM DD YY
17. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY
19. OUTSIDE LAST 8 CHARGES
20. PRIOR AUTHORIZATION NUMBER
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL, even if not listed below) ICD-9-CM
A. B. C. D. E. F. G. H. I. J. K. L.
22. PHYSICIAN OR SUPPLIER SIGNATURE (I certify that the statements on this form are true and correct to the best of my knowledge and belief.)
23. SERVICE FACILITY LOCATION INFORMATION
24. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on this form are true and correct to the best of my knowledge and belief.)
25. FEDERAL TAX ID NUMBER SSN SSN
26. PATIENT'S ACCOUNT NO.
27. SERVICE ASSIGNMENT? YES NO
28. TOTAL CHARGE \$
29. AMOUNT PAID \$
30. REMAINING MUCC USE

1. 2. 3. 4. 5. 6.

25. FEDERAL TAX ID NUMBER SSN SSN 26. PATIENT'S ACCOUNT NO. 27. SERVICE ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. REMAINING MUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on this form are true and correct to the best of my knowledge and belief.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ()

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER RY (LINE) OTHER										14. INSURED'S ID NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S ADDRESS (No. Street)										7. INSURED'S ADDRESS (No. Street)									
5. PATIENT'S RELATIONSHIP TO INSURED										11. INSURED'S POLICY GROUP OR POLICY NUMBER									
6. RESUBMITTED FOR MUCC USE										12. INSURED'S DATE OF BIRTH									
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE									
9. OTHER INSURED'S POLICY OR GROUP NUMBER										15. OTHER DATE									
10. IS PRESENT'S CONDITION RELATED TO										16. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S									
11. INSURED'S POLICY GROUP OR POLICY NUMBER										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
12. INSURED'S DATE OF BIRTH										18. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE										19. OUTSIDE LAB									
14. INSURED'S POLICY GROUP OR POLICY NUMBER										20. PHYSICIAN'S									
15. OTHER DATE										21. PRIOR AUTHORIZATION NUMBER									
16. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN'S										22. PHYSICIAN'S									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										23. PHYSICIAN'S									
18. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)										24. PHYSICIAN'S									
19. OUTSIDE LAB										25. PHYSICIAN'S									
20. PHYSICIAN'S										26. PHYSICIAN'S									
21. PRIOR AUTHORIZATION NUMBER										27. PHYSICIAN'S									
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Line Item 15

- Not required
- Not mapped electronically

Line Item 16

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

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

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

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

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

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

CITY STATE 8. RESERVED FOR NUCC USE OFF STATE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PHYSICIAN'S CONDITION RELATED TO 11. INSURED'S POLICY OR GROUP OR 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 contribution to input it to the party who accepts assignment below.) 13. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 14. INSURED'S POLICY OR GROUP OR FECA NUMBER

15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the designated physician or supplier for services described below.) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL entries below) (ICD-9-CM) 22. PHYSICIAN OR SUPPLIER'S SIGNATURE (ORIGINAL REQUIRED) 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) B. PLACE OF SERVICE (INDICATE) C. PROCEDURE, SERVICE, OR SUPPLY (Indicate Unusual Circumstances) D. DIAGNOSIS (ICD-9-CM) E. CHARGE (S) F. CHARGE (S) G. CHARGE (S) H. CHARGE (S) I. CHARGE (S) J. CHARGE (S) K. CHARGE (S) L. CHARGE (S)

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

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

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR NUCC USE

11. RESERVED FOR NUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREEXISTING DISEASE

15. OTHER DATE

16. DATE OF BIRTH

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NPI

17b. NPI

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

19. OTHER DATE

20. DATE OF BIRTH

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. PHYSICIAN OR SUPPLIER

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. CREDIT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. RESERVE NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PAY ()

Line Items 17 and 17b

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

EMC Equivalent Lines 17 and 17b

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

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR MUCC USE

11. RESERVED FOR MUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

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

21. PHYSICIAN OR SUPPLIER INFORMATION

22. PHYSICIAN OR SUPPLIER INFORMATION

23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE FROM TO B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. 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. 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.

Line Item 18

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

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

Line Item 19

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

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

PCIA ☐ NCA ☐

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

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

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Include Area Code)

17. INSURED'S POLICY OR GROUP OR FICA NUMBER

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

19. INSURED'S SEX (M/F)

20. OTHER CLAIM ID (Designated by NUCC)

21. INSURANCE PLAN NAME OR PROGRAM NAME

22. IS THERE ANOTHER HEALTH BENEFIT PLAN?

23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

24. DATE OF CURRENT SERVICE, INJURY, OR PROGRAMS (MM/DD/YY)

25. OTHER DATE (MM/DD/YY)

26. DATE OF LAST WORK IN CURRENT OCCUPATION (MM/DD/YY)

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

28. OUTSIDE LAB?

29. PHYSICIAN OR SUPPLIER INFORMATION

30. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

31. PHYSICIAN OR SUPPLIER INFORMATION

32. PHYSICIAN OR SUPPLIER INFORMATION

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100. PHYSICIAN OR SUPPLIER INFORMATION



EMC Equivalent Line 19

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

Line Item 20

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

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

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

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

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

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Include Area Code)

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

18. OTHER INSURED'S POLICY OR GROUP NUMBER

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

20. IS PATIENT EMPLOYED (Current or Previous)?

21. IS PATIENT AN AUTO ACCIDENT?

22. IS PATIENT AN OTHER ACCIDENT?

23. IS THERE ANOTHER HEALTH BENEFIT PLAN?

24. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

26. DATE OF CURRENT SURVIVAL SURVEY OR PREVIOUSLY (MM/DD/YY)

27. OTHER DATA (MM/DD/YY)

28. NAME OF REFERRING PROVIDER OR OTHER SOURCE

29. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)

30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include AC, E, or other code below)

31. OUTSIDE LAB?

32. CHARGES

33. PRIOR AUTHORIZATION NUMBER

34. FEDERAL TAX ID NUMBER

35. PATIENT'S ACCOUNT NO.

36. SERVICE ASSIGNMENT?

37. TOTAL CHARGE

38. AMOUNT PAID

39. BILLING PROVIDER INFO & PH#

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER (For Programs in Item 1)										14. INSURED'S ID NUMBER									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										15. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S ADDRESS (No. Street)										16. INSURED'S ADDRESS (No. Street)									
4. CITY STATE ZIP CODE TELEPHONE (Include Area Code)										17. CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										18. IS PRESENT'S CONDITION RELATED TO:									
6. OTHER INSURED'S POLICY OR GROUP NUMBER										19. INSURED'S POLICY GROUP OR POLA NUMBER									
7. RESERVED FOR NUCC USE										20. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)									
8. RESERVED FOR NUCC USE										21. OTHER CLAIMS (Designated by NUCC)									
9. INSURANCE PLAN NAME OR PROGRAM NAME										22. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
10. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be made to the party who accepts assignment below.										23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)									
11. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED (MM DD YY) QUAL ()										24. DATE OF BIRTH (MM DD YY) SEX (M F) WORK IN CURRENT OCCUPATION ()									
12. NAME OF REFERRING PROVIDER OR OTHER SOURCE ()										25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES ()									
13. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										26. OUTSIDE LAB? ()									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (242))										27. PHYSICIAN OR SUPPLIER INFORMATION									
A. B. C. D. E. F. G. H. I. J. K. L.										28. PHYSICIAN OR SUPPLIER INFORMATION									
25. FEDERAL TAX ID NUMBER ()										29. PATIENT'S ACCOUNT NO.									
26. SIGNATURE OF PHYSICIAN OR SUPPLIER ()										30. SERVICE FACILITY LOCATION INFORMATION									
27. SIGNATURE OF PHYSICIAN OR SUPPLIER ()										31. BILLING PROVIDER INFO & PAY ()									

Line Item 21

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

EMC Equivalent Line 21

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



- Not required
- Not mapped electronically



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER RY (LINE) OTHER										14. INSURED'S ID NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M F									
5. PATIENT'S ADDRESS (No. Street)										7. INSURED'S ADDRESS (No. Street)									
CITY STATE ZIP CODE TELEPHONE (Include Area Code)										CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PRESENT CONDITION RELATED TO:									
4. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR POLA NUMBER									
5. RESERVED FOR NUCC USE										12. INSURED'S DATE OF BIRTH MM DD YY SEX M F									
6. RESERVED FOR NUCC USE										13. OTHER CLAIMS (See guidelines in NUCC)									
8. INSURANCE PLAN NAME OR PROGRAM NAME										14. INSURANCE PLAN NAME OR PROGRAM NAME									
15. CLAIM CODES (Designated by NUCC)										16. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
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 or payment credits to be assigned to the party who accepts assignment below.										18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the assigned physician or supplier for services described below.									
19. DATE OF CURRENT ILLNESS, INJURY, OR PREEXISTING DISEASE										20. OTHER DATE									
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE										22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										24. OUTSIDE LAB?									
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-10 code below)										26. PHYSICIAN OR SUPPLIER INFORMATION									
27. PRIOR AUTHORIZATION NUMBER										28. PHYSICIAN OR SUPPLIER INFORMATION									
29. A. CARRIER OF SERVICE From To PLACE OF SERVICE										30. PROCEDURE, SERVICE, OR SUPPLY (Designated by NUCC)									
31. MEDICAL TAX ID NUMBER										32. PATIENT'S ACCOUNT NO.									
33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials)										34. SERVICE FACILITY LOCATION INFORMATION									
35. BILLING PROVIDER INFO & PAY ()										36. BILLING PROVIDER INFO & PAY ()									

Line Item 23

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

EMC Equivalent Line 23

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



HEALTH INSURANCE CLAIM FORM

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

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

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

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

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

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

4. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT (Current or Former) 6. INSURED'S DATE OF BIRTH MM DD YY SEX

5. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) 8. OTHER CLAIMS (Date paid by NUCC)

6. RESERVED FOR NUCC USE c. OTHER ACCIDENT? 9. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

SIGNED DATE SIGNED

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE CLAIM 21. PHYSICIAN CODE ORIGINAL REF. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, even inactive before date) 22. PRIOR AUTHORIZATION NUMBER

Line Items 24A–24J

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

EMC Equivalent Lines 24A–24J

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 03/12

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

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

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

CITY STATE 8. RESIDENT FOR NUCC USE CITY STATE

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

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

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

15. RESERVED FOR NUCC USE 16. AUTO ACCIDENT? 17. OTHER CLAIMED (See Guidance by NUCC) 18. INSURANCE PLAN NAME OR PROGRAM NAME

19. RESERVED FOR NUCC USE 20. OTHER ACCIDENT? 21. IS THERE ANOTHER HEALTH BENEFIT PLAN? 22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be made to the party who accepts assigned below.)

23. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credits to be made to the party who accepts assigned below.)

24. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 25. OTHER DATE 26. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

27. NAME OF REFERRING PROVIDER OR OTHER SOURCE 28. SSN 29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

30. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 31. OUTSIDE CLAIM 32. PHYSICIAN OR SUPPLIER INFORMATION

33. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, even those below ICD-9) 34. PHYSICIAN OR SUPPLIER INFORMATION

35. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

36. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

37. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

38. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

39. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

40. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

41. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

42. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

43. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

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74. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

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84. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

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93. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

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95. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

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98. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

99. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

100. A. CARRIER OF SERVICE FROM B. C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. PHYSICIAN OR SUPPLIER INFORMATION

Line Item 25

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
25	Federal Tax ID number	2010AA	REF02	Billing Provider Tax ID	Enter the provider of service Federal Tax ID/EIN (EI) or SSN (SY) of the billing provider/group.
	SSN Indicator		REF01	Social Security number	
	EIN Indicator		REF01	Employer's ID number	

Line Item 26

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
26	Patient's Account number	2300	CLM01	Provider Assigned Account number	Enter the patient's account number assigned by the provider of service's accounting system. As a service, any account number will be returned to you up to 20 characters.

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

PCIA ☐ NCA ☐

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. PATIENT'S SEX (M/F)

10. PATIENT'S RELATIONSHIP TO INSURED

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

12. INSURED'S ADDRESS (No. Street)

13. CITY

14. STATE

15. ZIP CODE

16. TELEPHONE (Include Area Code)

17. INSURED'S POLICY OR GROUP NUMBER

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

19. INSURED'S SEX (M/F)

20. INSURED'S EMPLOYMENT (Current or Former)

21. INSURED'S AUTO ACCIDENT?

22. INSURED'S OTHER ACCIDENT?

23. INSURED'S CLAIM CODES (Designated by NUCC)

24. IS THERE ANOTHER HEALTH BENEFIT PLAN?

25. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

26. DATE

27. SIGNED

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

29. OTHER DATE

30. NAME OF REFERRING PROVIDER OR OTHER SOURCE

31. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL, even when below 4000)

33. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

34. OUTSIDE LAB?

35. PHYSICIAN OR SUPPLIER INFORMATION

36. PRIOR AUTHORIZATION NUMBER

37. A. CARRYING OF SERVICE

38. B. PROCEDURE, SERVICE, OR SUPPLY

39. C. CHARGES

40. D. TOTAL CHARGE

41. E. AMOUNT PAID

42. F. PROVIDER'S ACCOUNT NO.

43. G. SIGNATURE OF PHYSICIAN OR SUPPLIER

44. H. BILLING PROVIDER INFO & Print

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR MUCC USE

11. RESERVED FOR MUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment or government benefits other than payment to the party who accepts assignment below.

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

15. OTHER DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM code and ICD-10 code)

20. PHYSICIAN OR SUPPLIER INFORMATION

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

22. SERVICE FACILITY LOCATION INFORMATION

23. BILLING PROVIDER INFO & PAY ()

24. MEDICAL TAX ID NUMBER

25. PATIENT'S ACCOUNT

26. TOTAL CHARGE

27. AMOUNT PAID

28. RESERVED FOR MUCC USE

29. ACCEPT ASSIGNMENT? (YES/NO)

Line Item 27

- Assignment: check yes or no
- Mandatory assignment for certain services
 - Clinical diagnostic laboratory services and physician lab services
 - Physician services to individuals dually entitled to Medicare and Medicaid
- Mandatory assignment for certain practitioners and providers
 - Physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	CLM07	Assignment or Plan Participation code	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not assigned

Line Items 28, 29 and 30

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

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

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

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

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

3. PATIENT'S ADDRESS (No. Street)

4. CITY

5. STATE

6. ZIP CODE

7. TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. RESERVED FOR NUCC USE

11. RESERVED FOR NUCC USE

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. IS PATIENT'S CONDITION RELATED TO:

14. EMPLOYMENT (Current or Former)

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. CLAIM CODES (Designated by NUCC)

18. IS THERE ANOTHER HEALTH BENEFIT PLAN?

19. 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 due to me or to the party who accepts assignment below.)

20. DATE

21. SIGNED

22. DATE OF CURRENT SURGICAL INJURY, IF PREVIOUSLY CLAIMED

23. OTHER DATE

24. NAME OF REFERRING PROVIDER OR OTHER SOURCE

25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

27. ICD-9

28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

29. OUTPATIENT LARI

30. CHARGES

31. ORIGINAL REF. NO.

32. PRIOR AUTHORIZATION NUMBER

33. A. CATHETER OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) 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. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials if party that the claim is to be paid to)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PIN #

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE JULY 05/12

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

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

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

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

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

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

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

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

11. RESERVED FOR MUCC USE 12. OTHER ACCIDENT? 13. INSURANCE PLAN NAME OR PROGRAM NAME

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

14. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment or payment credit to be paid to the party who accepts assigned claim.) 16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the authorized physician or supplier for services described below.)

SIGNED DATE SIGNED

17. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUS CLAIM 18. OTHER DATE 19. DATE OF BIRTH (MM/YY) 20. DATE OF BIRTH (MM/YY) 21. DATE OF BIRTH (MM/YY)

22. NAME OF REFERRING PROVIDER OR OTHER SOURCE 23. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO) 24. OUTSIDE LAB? \$ CHARGE

25. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) 26. YES NO 27. PHYSICIAN OR SUPPLIER INFORMATION (See Instructions)

28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide AC, ICD-9-CM, ICD-10, or other code) 29. PHYSICIAN OR SUPPLIER INFORMATION (See Instructions)

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. PATIENT'S ACCOUNT NO. 33. ACCOUNT ASSIGNMENT? (YES/NO) 34. TOTAL CHARGE 35. AMOUNT PAID 36. RESERVED FOR MUCC USE

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

SIGNED DATE

Line Item 31

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

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

Line Item 32

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DISC BOX (LINE 10) OTHER 1% INSURED'S I.D. NUMBER (For Program in Item 1)

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

5. PATIENT'S ADDRESS (incl. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (incl. Street)

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

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

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

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

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

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

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

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

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

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

41. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Nurse AC, Enter on the back of this form) 42. PHYSICIAN OR SUPPLIER SIGNATURE (Original or Photocopy) 43. PHYSICIAN OR SUPPLIER NPI

44. A. B. C. D. E. F. G. H. I. J. K. L. 45. PHYSICIAN OR SUPPLIER SIGNATURE (Original or Photocopy) 46. PHYSICIAN OR SUPPLIER NPI

47. DATE OF SERVICE (MM DD YY) 48. PLACE OF SERVICE (MM DD YY) 49. PHYSICIAN OR SUPPLIER SIGNATURE (Original or Photocopy) 50. PHYSICIAN OR SUPPLIER NPI

51. REGIONAL TAX ID NUMBER 52. SERVICE FACILITY LOCATION INFORMATION 53. TOTAL CHARGE 54. AMOUNT PAID 55. RESERVED FOR NUCC USE

56. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials to carry that the statements on this reverse apply to this bill and are in full and final) 57. BILLING PROVIDER INFO & P# ()

PCSA										PCSA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN ISCR NO. (USE) OTHER					10. INSURED'S I.D. NUMBER (for Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
3. PATIENT'S ADDRESS (No. Street)					7. INSURED'S ADDRESS (No. Street)						
CITY STATE ZIP CODE TELEPHONE (Include Area Code)					CITY STATE ZIP CODE TELEPHONE (Include Area Code)						
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					11. INSURED'S POLICY GROUP OR PLAN NUMBER						
9. OTHER INSURED'S POLICY OR GROUP NUMBER					12. INSURED'S DATE OF BIRTH						
10. IS PATIENT'S CONDITION RELATED TO:					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 release payment of government benefits either to myself or to the party who accepts assignment below.)						
11. EMPLOYMENT (Current or Previous)					14. DATE OF CURRENT SURVIVAL, INJURY, OR FREQUENTLY ILL						
12. AUTO ACCIDENT?					15. OTHER DATE						
13. OTHER ADD DENT?					16. DATE OF BIRTH (Current or Previous)						
14. CLAIM CODES (Designated by NUCC)					17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
15. IS THERE ANOTHER HEALTH BENEFIT PLAN?					18. OUTSIDE LAB?						
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 release payment of government benefits either to myself or to the party who accepts assignment below.)					19. HEMORRHOID CODE						
17. PRIOR AUTHORIZATION NUMBER					20. BILLING PROVIDER INFO & Pmt #						
21. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on this form are true and correct to the best of my knowledge.)					22. TOTAL CHARGE						
23. SERVICE FACILITY LOCATION INFORMATION					24. BILLING PROVIDER INFO & Pmt #						

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

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

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

 national government SERVICES  54

HEALTH INSURANCE CLAIM FORM												PATIENT AND INSURED INFORMATION	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012												NUCC 0012	
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ SELF-EMPLOYED ☐ OTHER ☐												14. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last name, first name, middle initial) 3. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code)												4. INSURED'S NAME (Last name, first name, middle initial) 5. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code)	
6. OTHER INSURED'S NAME (Last name, first name, middle initial) 7. OTHER INSURED'S POLICY OR GROUP NUMBER 8. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. INSURANCE PLAN NAME OR PROGRAM NAME												11. INSURED'S POLICY GROUP OR POLICY NUMBER 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX ☐ M ☐ F 13. OTHER CLAIM ID (as designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO (If yes, complete items 16, 17, and 18)	
16. DATE OF CURRENT ILLNESS, INJURY, OR PHYSICIAN CLAIM (MM DD YY) QUAL ☐ MED ☐ SURG ☐												17. DATE OF PHYSICIAN CLAIM (MM DD YY) QUAL ☐ MED ☐ SURG ☐	
19. NAME OF PROVIDING PROVIDER OR OTHER SOURCE 20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												21. HOSPITALIZATION DATES RELATIVE TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 22. OUTPATIENT LATE ☐ YES ☐ NO ☐ SCHEDULED 23. PHYSICIAN CODE ORIGINAL REP. NO. 24. PRIOR AUTHORIZATION NUMBER	
25. DATE OF SERVICE FROM MM DD YY TO MM DD YY 26. PLACE OF SERVICE (FACILITY) 27. PROVIDER'S NAME (Last name, first name, middle initial) 28. PHYSICIAN CODE 29. DATE OF SERVICE (MM DD YY) 30. PHYSICIAN CODE 31. PROVIDING PROVIDER ID #												32. BILLING PROVIDER INFO & PH # ()	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address or credentials (I certify that the statements on this form are true and correct to the best of my knowledge and belief))												34. SERVICE FACILITY LOCATION INFORMATION	

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

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

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

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

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

Claim Rejection Reminders

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

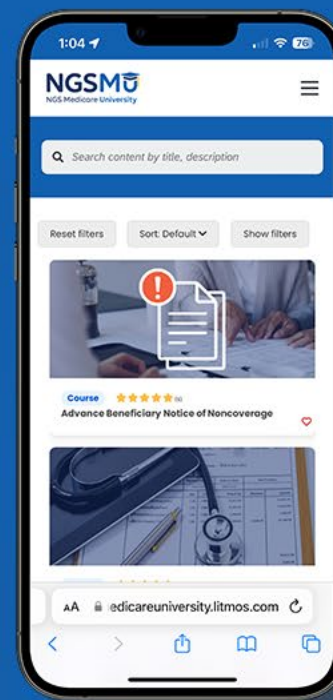
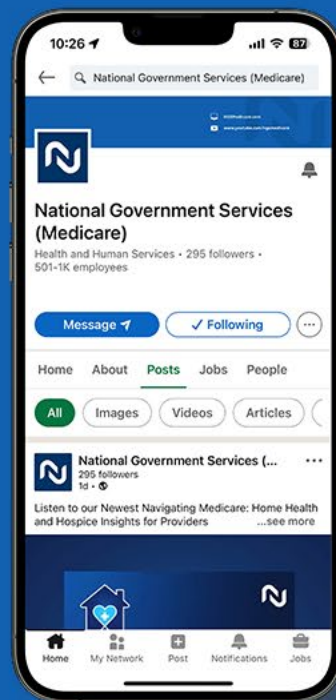
Resources, References and Tools

Resources and References

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

Questions?

Thank you!



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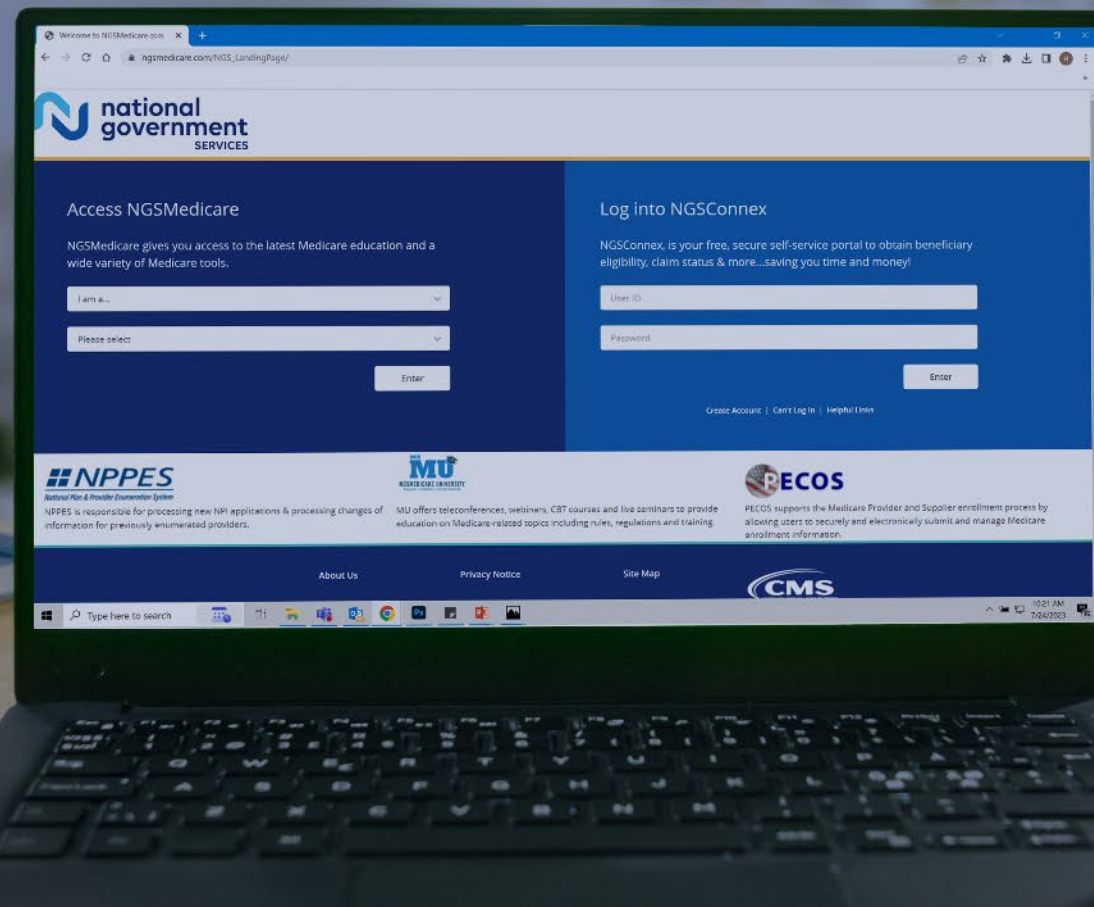


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Web portal for claim information



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