

Proper Medicare Part B Claim Submissions

7/26/2023

Today's Presenters

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Objectives

After completion attendees will be able to

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



Agenda

Claim Form Requirements

Claims Filing Time Limit

Administrative Simplification
Compliance Act

Paper and Electronic Claim Overview

Resources, References and Tools

Claim Form Requirements



Claim Submission Requirements

- Paper

- Original CMS-1500 Claim Form
- Data should not be touching box edges or running outside of numbered boxes
- Cannot contain more than six service lines per claim
- No stickers, bold, italics, or underlining

- Electronic or paper

- Do not use narrative or handwritten descriptions
 - ✓ Procedure, modifier or diagnosis
- Do not use special characters
 - ✓ hyphens, periods, parentheses, dollar signs or ditto marks

Time Limits for Filing Medicare Claims

Claim Filing Time Limits

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



ASCA Regulations

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

Claim Form Overview

CMS-1500 Claim Form (02/12)

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

PATIENT AND INSURER INFORMATION

Beneficiary data

Provider data

PROVIDER OR SUPPLIER INFORMATION



NUCC Approved OMB

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12



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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA EXCLUDED (OW) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										3. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
4. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										5. INSURED'S NAME (Last Name, First Name, Middle Initial)									
6. OTHER INSURED'S POLICY OR GROUP NUMBER										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
8. RESERVED FOR NUCC USE										9. RESERVED FOR NUCC USE									
9. OTHER INSURED'S POLICY OR GROUP NUMBER										10. IS PATIENT'S CONDITION RELATED TO:									
10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FICA NUMBER									
11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										12. OTHER CLAIM ID (Designated by NUCC)									
12. OTHER CLAIM ID (Designated by NUCC)										13. INSURED'S PLAN NAME OR PROGRAM NAME									
13. INSURED'S PLAN NAME OR PROGRAM NAME										14. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 3, 9a, and 9d										15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION										17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES										18. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
18. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										19. RESUBMISSION CODE ORIGINAL REF. NO.									
19. RESUBMISSION CODE ORIGINAL REF. NO.										20. PRIOR AUTHORIZATION NUMBER									
20. PRIOR AUTHORIZATION NUMBER										21. DATE(S) OF SERVICE									
21. DATE(S) OF SERVICE										22. PROCEDURES, SERVICES, OR SUPPLIES									
22. PROCEDURES, SERVICES, OR SUPPLIES										23. FICA EXCLUDED (OW)									
23. FICA EXCLUDED (OW)										24. DATE(S) OF SERVICE									
24. DATE(S) OF SERVICE										25. PATIENT'S ACCOUNT NO.									
25. PATIENT'S ACCOUNT NO.										26. ACCEPT & AGREEMENT?									
26. ACCEPT & AGREEMENT?										27. TOTAL CHARGE									
27. TOTAL CHARGE										28. AMOUNT PAID									
28. AMOUNT PAID										29. PAYABLE BY/TO									
29. PAYABLE BY/TO										30. SIGNING PROVIDER INFO & Print #									
30. SIGNING PROVIDER INFO & Print #										31. SIGNATURE OF PHYSICIAN OR SUPPLIER									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION									
32. SERVICE FACILITY LOCATION INFORMATION										33. SIGNATURE OF PHYSICIAN OR SUPPLIER									
33. SIGNATURE OF PHYSICIAN OR SUPPLIER										34. SIGNATURE OF PHYSICIAN OR SUPPLIER									

Line Item 1

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

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

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

Line Item 1a

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

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

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

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

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

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

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

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

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED (MR, MRS, MS, MISS, CHILD, OTHER)

7. INSURED'S ADDRESS (No. Street)

8. CITY

9. STATE

10. ZIP CODE

11. TELEPHONE (Include Area Code)

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

13. IS PATIENT'S CONDITION RELATED TO (YES/NO)

14. INSURED'S POLICY OR GROUP NUMBER

15. EMPLOYMENT (Current or Previous) (YES/NO)

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

17. RESERVED FOR NUCC USE

18. AUTO ACCIDENT? (YES/NO)

19. OTHER CLAIM ID (Designated by NUCC)

20. INSURANCE PLAN NAME OR PROGRAM NAME

21. CLAIM CODES (Designated by NUCC)

22. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO)

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

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

25. HOSPITALIZATION DATES RELATES TO CURRENT SERVICES (FROM/TO)

26. OUTSIDE LAB? (YES/NO)

27. RE submission CODE

28. PRIOR AUTHORIZATION NUMBER

29. DATES OF SERVICE (From/To)

30. PROCEDURES, SERVICES OR SUPPLIES (Specify Usual Circumstances)

31. DIAGNOSIS MONITOR

32. TOTAL CHARGE

33. AMOUNT PAID

34. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statement on this reverse applies to the bill and is made a part thereof.)

35. SERVICE FACILITY LOCATION INFORMATION

36. BILLING PROVIDER INFO & PAY#

37. SIGNATURE

38. DATE

39. SIGNATURE

40. DATE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0035-11/97 (FORM 100-102-12)

Clear Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

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

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

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

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

5. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

6. INSURED'S ADDRESS (No. Street)

7. INSURED'S ADDRESS (No. Street)

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP FROM TO QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES YES NO

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

22. PRIOR AUTHORIZATION NUMBER

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

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Include Universal Descriptors) D. DIAGNOSIS PORTER E. \$ CHARGES F. DATE OF BILL G. DATE OF PAYMENT H. ICD-9-CM I. ORIGINAL REF. NO. J. RENDERING PROVIDER ID #

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (No bill sent yet) YES NO

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

31. BILLING PROVIDER INFO & PH # ()

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

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

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Line Item 2

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

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

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.)	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (Tricare) <input type="checkbox"/> CHAMPVA (Champion Victory) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> RESA BOX (Reserve Box) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
9. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F)		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)	
13. INSURED'S POLICY OR GROUP NUMBER		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP (MM, DD, YY) QUAL (Qual)	
15. RESERVED FOR NUCC USE		16. OTHER DATE (MM, DD, YY) QUAL (Qual)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO) (MM, DD, YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? (YES, NO) \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to end of line 24B) (ICD-10)		22. PRIOR AUTHORIZATION NUMBER	
23. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		24. SERVICE FACILITY LOCATION INFORMATION	
25. FEDERAL TAX ID NUMBER (SSN, EIN)		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (YES, NO)		28. TOTAL CHARGE \$	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		30. AMOUNT PAID \$	
31. BILLING PROVIDER INFO & PH# ()		32. PAYOR'S NUCC USE	

Line Item 4

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

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

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

Line Item 5

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

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

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA (JMW) OTHER 1a. INSURED'S I.D. NUMBER (For Programs 1-11)

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

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

CITY STATE CITY STATE

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

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

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

14. RESERVED FOR NUCC USE 15. AUTO ACCIDENT? YES NO PLACE (State) 16. OTHER CLAIM ID (Designated by NUCC)

17. RESERVED FOR NUCC USE 18. OTHER ACCIDENT? YES NO 19. INSURANCE PLAN NAME OR PROGRAM NAME

20. INSURANCE PLAN NAME OR PROGRAM NAME 21. CLAIM CODES (Designated by NUCC) 22. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 11, and 12

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

SIGNED DATE SIGNED DATE

25. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM QUAL MM YY 26. OTHER DATE QUAL MM YY

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

29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 30. OUTSIDE LAB? YES NO \$ CHARGE

31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in as many as apply) ICD-9-CM 32. RESUBMISSION CODE ORIGINAL REF. NO.

33. PRIOR AUTHORIZATION NUMBER

34. A. DATES OF SERVICE From To B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) E. DIAGNOSIS MONITOR 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. 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.

35. RECEIPT/TAX I.D. NUMBER 36. PATIENT'S ACCOUNT NO. 37. ACCOUNT ASSIGNMENT? YES NO 38. TOTAL CHARGE \$ 39. AMOUNT PAID \$ 40. Refund for NUCC Use

41. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 42. SERVICE FACILITY LOCATION INFORMATION 43. BILLING PROVIDER INFO & PAYE ()

SIGNED DATE SIGNED DATE

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

Clear Form

NCA										PCA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> SELF-PAID <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (TRICARE) (Member ID) (ID) (ID) (ID)</small>										14. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> A. INSURED'S SOCIAL SECURITY #									
CITY STATE ZIP CODE TELEPHONE (Include Area Code)										CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
4. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										100. CLAIM CODES (Designated by NUCC)									
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.																			
SIGNED DATE										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (EMP) MM DD YY QUAL										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Or Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Repeat ALL to cover line below 24B) ICD 9d										22. PREMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Include Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DATE OF BIRTH H. AGE I. D. QUAL J. REFERRING PROVIDER ID #																			
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3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX ID NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
27. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statements on the reverse apply to this bill and are made a part hereof.)										27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. SERVICE FACILITY LOCATION INFORMATION										28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Payer by NUCC Use									
31. BILLING PROVIDER INFO & PH#																			
SIGNED DATE										SIGNED									

Line Item 6

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

6. PATIENT RELATIONSHIP TO INSURED

Self ☐ Spouse ☐ Child ☐ Other ☐

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

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

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

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) (2/72)

PATIENT AND INSURED INFORMATION									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> OTHER <input type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)									
6. INSURED'S ADDRESS (No., Street)									
7. CITY									
8. STATE									
9. ZIP CODE									
10. TELEPHONE (Include Area Code)									
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
12. IS PATIENT'S CONDITION RELATED TO:									
13. EMPLOYMENT (Current or Previous)									
14. AUTO ACCIDENT									
15. OTHER ACCIDENT									
16. INSURANCE PLAN NAME OR PROGRAM NAME									
17. CLAIM CODES (Designated by NUCC)									
18. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
19. SIGNATURE OF PATIENT OR AUTHORIZED PERSON									
20. DATE									
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
23. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM									
24. DATE OF REFERRAL									
25. HORIZONTAL DATES RELATED TO CURRENT SERVICES									
26. OUTSIDE LAB?									
27. REGISTRATION CODE									
28. PRIOR AUTHORIZATION NUMBER									
29. FEDERAL TAX ID NUMBER									
30. PATIENT'S ACCOUNT NO.									
31. TOTAL CHARGE									
32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & Print									
34. SIGNATURE OF PHYSICIAN OR SUPPLIER									
35. DATE									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0935-1157 FORM 100-106-12

Clear Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (Champion of Veterans Affairs) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BOX CLING (FECA Box Cling) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Grandchild, Other)		9. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
10. IS PATIENT'S CONDITION RELATED TO (a) EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO (b) AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO (c) OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assigned benefit.)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) (MM/DD/YY) QUAL ()		15. OTHER DATE (MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read A.L. to L. and write in box 24B) (ICD-9-CM)		22. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE () C. PROCEDURES, SERVICES, OR SUPPLIES (Diagnose Unusual Circumstances) (Diagnose Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DATE OF SERVICE (MM/DD/YY) G. DATE OF SERVICE (MM/DD/YY) H. DATE OF SERVICE (MM/DD/YY) I. DATE OF SERVICE (MM/DD/YY) J. RENDERING PROVIDER ID #		25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (No prior bill, per US) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Provider NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the lower so apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()	

Line Item 8

- Reserved for future NUCC use
- Not mapped electronically

8. RESERVED FOR NUCC USE

Line Items 9, 9a-9d

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

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

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

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

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

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

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

8. RESERVED FOR NUCC USE 9. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO d. CLAIM CODES (Designated by NUCC)

10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below. 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM MM/DD/YY QUAL 13. OTHER DATE MM/DD/YY QUAL 14. INSURED'S DATE OF BIRTH MM/DD/YY SEX M F

15. NAME OF REFERRING PROVIDER OR OTHER SOURCE 16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY

17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 18. OUTSIDE LAB? YES NO 19. RESUBMISSION CODE 20. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in as many as apply) ICD-9-CM A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

22. DATES OF SERVICE From MM/DD/YY To MM/DD/YY 23. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) CPT/HCPCS MODIFIER 24. DIAGNOSIS MONITOR 25. TOTAL CHARGE \$ 26. AMOUNT PAID \$ 27. BILLING PROVIDER INFO & PH# ()

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

SIGNED DATE SIGNED DATE 31. 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Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
9*	Other insured's Name (Last, First, Middle Initial)	2333A	NM103	Other insured last name	Name of insured for Medicaid plan
			NM104	Other insured first name	
			NM105	Other insured middle name	
9e*	Other insured's policy or group number (Medicaid only)	2333A	NM106	Identification Code Qualifier (M Member Identification Number)	Medicaid policy ID
			NM108	Other insured identifier	Medicaid P Primary S Secondary T Tertiary
		2320	SR031	Payer responsibility	
			SR033	Insured group or policy number	Enter the insured's group or plan number
9e*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medicaid Address)	2333B	N401	Other payer city name	Enter the city, state and ZIP code of the insurer. Required if any other payers are known to potentially be involved in paying this claim.
			N402	Other payer state code	
			N403	Other payer ZIP code	
9e*	Insurance plan name or program name	2333B	NM106	Other payer identification Code Qualifier	Medicaid plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	



APPROVED CMB-0638-1197 FORM 100 (02-12)

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- ? VW[US[V UdaeeahVde SdWSgfa_ Sf[Uh[S
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? VW[US[V UdaeeahVde
- @af_ SbbVW VWVfda` [US^k

10d. CLAIM CODES (Designated by NUCC)

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

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

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

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

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

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER b. EMPLOYMENT? (Current or Previous) YES NO 12. INSURED'S DATE OF BIRTH MM / DD / YY SEX M F

c. RESERVED FOR NUCC USE d. AUTO ACCIDENT? PLACE (Blank) YES NO e. OTHER CLAIM ID (Designated by NUCC)

f. OTHER ACCIDENT? YES NO 13. INSURANCE PLAN NAME OR PROGRAM NAME 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 14, 15, and 16

10d. CLAIM CODES (Designated by NUCC) 15. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM QUAL. MM / DD / YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM / DD / YY TO MM / DD / YY

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO 21. DIAGNOSIS OR NATURE OF INJURY OR ILLNESS (Please fill in as many as apply) ICD-9S A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

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

24. A. DATES OF SERVICE From MM / DD / YY To MM / DD / YY B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances of Practice) E. DIAGNOSIS MONITOR F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 25. TOTAL CHARGE \$ 26. AMOUNT PAID \$ 27. BILLING PROVIDER INFO & PH# ()

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 29. SERVICE FACILITY LOCATION INFORMATION 30. BILLING PROVIDER INFO & PH# ()

SIGNED DATE SIGNED DATE SIGNED DATE SIGNED DATE SIGNED DATE SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 (FORM 100-102-12)

Clear Form



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (Tricare) <input type="checkbox"/> CHAMPVA (Champion of Veterans Affairs) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BOXING (FECA) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)		b. AUTO ACCIDENT? (Date)	
c. OTHER ACCIDENT? (Date)		d. OTHER CLAIM ID (Designated by NUCC)	
e. INSURANCE PLAN NAME OR PROGRAM NAME		f. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)	
13. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)	
15. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
17. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. OUTSIDE LAB? (YES/NO) \$ CHARGES	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to end of line 19B) (ICD-10)		20. PRIOR AUTHORIZATION NUMBER	
21. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		22. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
23. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		24. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
25. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		26. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
27. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		28. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
29. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		30. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
31. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		32. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
33. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		34. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
35. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		36. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
37. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		38. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
39. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		40. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
41. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		42. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
43. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		44. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
45. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		46. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
47. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		48. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
49. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		50. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
51. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		52. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
53. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		54. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
55. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		56. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
57. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		58. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
59. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		60. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
61. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		62. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
63. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		64. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
65. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		66. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
67. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		68. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
69. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		70. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
71. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		72. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
73. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		74. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
75. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		76. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
77. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		78. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
79. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		80. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
81. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		82. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
83. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		84. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
85. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		86. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
87. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		88. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
89. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		90. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
91. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		92. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
93. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		94. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
95. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		96. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
97. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		98. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
99. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		100. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	

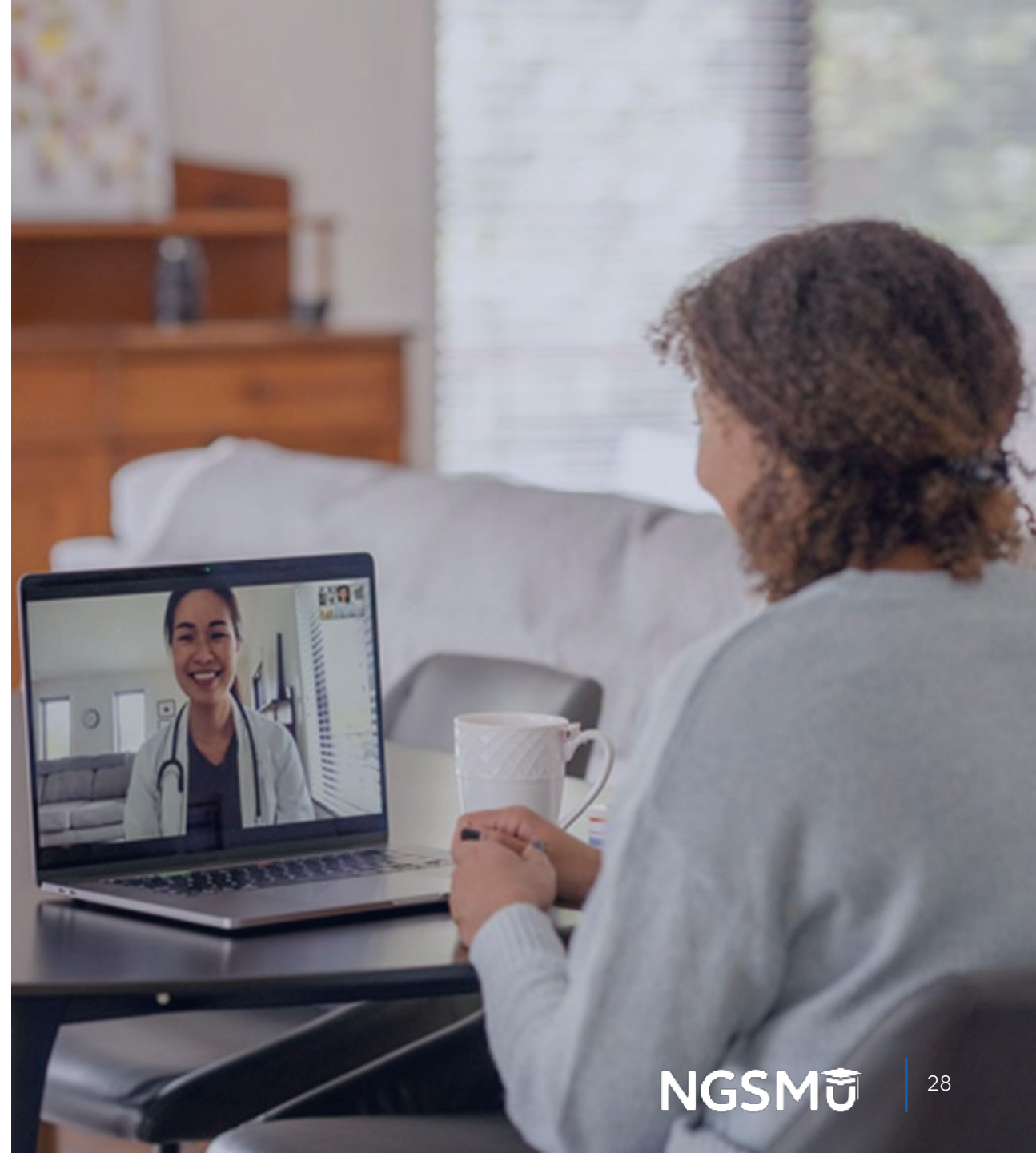
Line Items 11,11a-11d

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

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

EMC Equivalent Lines 11, 11a-11c

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





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (CHAMPVA) <input type="checkbox"/> OTHER HEALTH PLAN (Other Health Plan) <input type="checkbox"/> FECA BOX CLING (FECA Box Cling) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)	
7. INSURED'S ADDRESS (No., Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP (MM/DD/YY) QUAL ()	
15. OTHER DATE (MM/DD/YY) QUAL ()		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. OUTSIDE LAB? (YES/NO) \$ CHARGES ()	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. RESUBMISSION CODE () ORIGINAL REF. NO. ()	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to end of line 24B) (ICD-10) ()		22. PRIOR AUTHORIZATION NUMBER ()	
23. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) PLACE OF SERVICE ()		24. PROCEDURES, SERVICES, OR SUPPLIES (Diagnose Unusual Circumstances) (CPT/HCPCS) ()	
25. FEDERAL TAX ID NUMBER ()		26. PATIENT'S ACCOUNT NO. ()	
27. ACCEPT & ASSIGNMENT? (No prior auth. req. for SSI) (YES/NO)		28. TOTAL CHARGE () 29. AMOUNT PAID ()	
30. 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.)		31. SERVICE FACILITY LOCATION INFORMATION ()	
32. BILLING PROVIDER INFO & PH# ()		33. BILLING PROVIDER NPI ()	

Line Item 12

Signature and date

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____



Line Item 13

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

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

SIGNED

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

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

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐ 1a. INSURED'S I.D. NUMBER (For Programs 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n, 1o, 1p, 1q, 1r, 1s, 1t, 1u, 1v, 1w, 1x, 1y, 1z)

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

CITY STATE CITY STATE

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

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

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

b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Blank) YES NO c. OTHER ACCIDENT? YES NO c. INSURANCE PLAN NAME OR PROGRAM NAME

d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 1a, 1b, and 1c.

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

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

SIGNED DATE 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 other than myself or to the party who accepts assignment of benefits.

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in to avoid the above) ICD-9-CM CODE 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From MM / DD / YY To MM / DD / YY B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) E. DIAGNOSIS MONITOR F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

25. FEDERAL TAX I.D. NUMBER SSN ID# 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Fee for NUCC Use

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

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

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Clear Form

[illegible]

Line Item 14

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

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

MM	DD	YY	QUAL

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

Line Item 15

- Not required
- Not mapped electronically

15. OTHER DATE			
QUAL		MM	DD YY

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

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

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE 9. 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: a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO c. OTHER ACCIDENT? ☐ YES ☐ NO 11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX ☐ M ☐ F 13. OTHER CLAIM ID (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15a. CLAIM CODES (Designated by NUCC) 16. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 19, 20, and 21.

17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.) 18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

SIGNED DATE SIGNED DATE

19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM/DD/YY) QUAL 20. OTHER DATE (MM/DD/YY) 21. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY) 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY) 23. OUTSIDE LAST \$ CHARGES ☐ YES ☐ NO 24. PRIOR AUTHORIZATION NUMBER 25. PRIOR AUTHORIZATION NUMBER

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in as many as apply) ICD-10 CODE A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 27. RESUBMISSION CODE ORIGINAL REF. NO. 28. PRIOR AUTHORIZATION NUMBER

29. A. DATES 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. 30. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) 31. DIAGNOSIS MONITOR 32. CHARGES 33. DATE OF BIRTH 34. QUAL 35. RENDERING PROVIDER ID #

1 2 3 4 5 6

36. FEDERAL TAX I.D. NUMBER 37. PATIENT'S ACCOUNT NO. 38. ACCOUNT ASSIGNMENT? ☐ YES ☐ NO 39. TOTAL CHARGE \$ 40. AMOUNT PAID \$ 41. Paid for NUCC Use

42. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 43. SERVICE FACILITY LOCATION INFORMATION 44. BILLING PROVIDER INFO & PH# ()

SIGNED DATE SIGNED DATE

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

Clear Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (Champion of the Americas) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other)		9. INSURED'S POLICY GROUP OR FECA NUMBER	
9. RESERVED FOR NUCC USE		10. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
b. AUTO ACCIDENT? (Date) YES <input type="checkbox"/> NO <input type="checkbox"/>		13. INSURED'S POLICY GROUP OR FECA NUMBER	
c. OTHER ACCIDENT? (Date) YES <input type="checkbox"/> NO <input type="checkbox"/>		14. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
15. INSURANCE PLAN NAME OR PROGRAM NAME		15. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
16. CLAIM CODES (Designated by NUCC)		16. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
17. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete Item 9, 10, and 11		17. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		18. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
19. SIGNED (Date)		19. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
20. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP)		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
21. OTHER DATE (MM/DD/YY)		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
22. NAME OF REFERRING PROVIDER OR OTHER SOURCE		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read ALL to determine both ICD and CPT)		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
25. ICD and CPT		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
26. A. DATE(S) OF SERVICE (From To) B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) D. DIAGNOSIS POINTER E. CHARGES F. DATE OF SERVICE G. DATE OF SERVICE H. DATE OF SERVICE I. DATE OF SERVICE J. RENDERING PROVIDER ID #		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
27. FEDERAL TAX ID NUMBER		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
28. PATIENT'S ACCOUNT NO.		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
29. ACCEPT ASSIGNMENT? (Yes/No)		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
30. TOTAL CHARGE		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
31. AMOUNT PAID		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
32. BILLING PROVIDER INFO & PH #		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the lower so apply to this bill and are made a part thereof.)		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
34. SERVICE FACILITY LOCATION INFORMATION		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
35. NPI		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
36. NPI		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0938-1197 FORM 1700102-12



Line Item 16




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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM MM DD YY TO MM DD YY

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

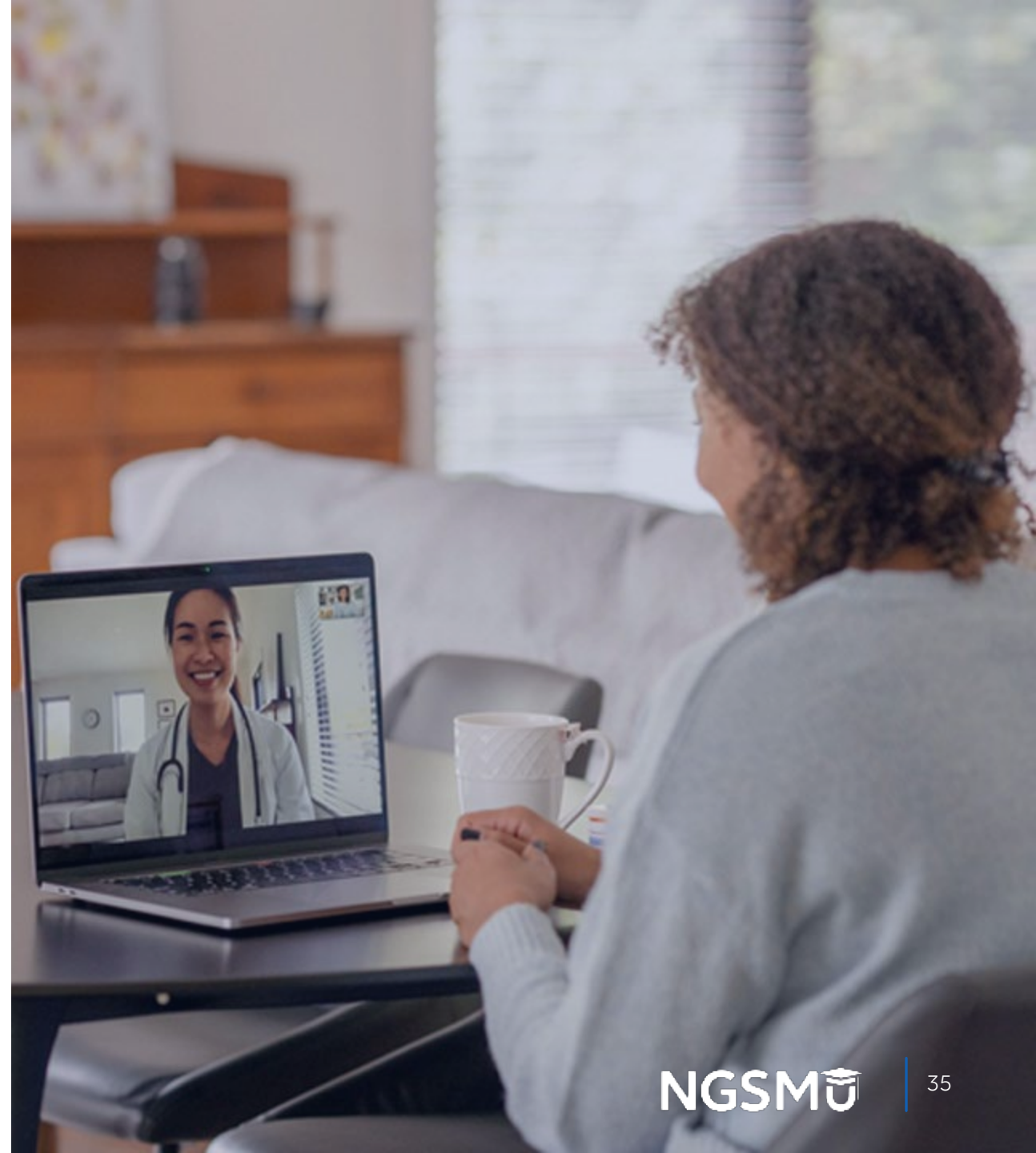
- Type of specialty legally eligible to order and refer Part B clinical laboratory and imaging services
- First and last name of referring or ordering physician as it appears in PECOS
 - Qualifier DN, DK or DQ to left of vertical line
 - Do not use Item 17a
- List NPI of referring, ordering or supervising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

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



EMC Equivalent Lines 17 and 17b

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





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE MEDICAID TRICARE CHAMPVA DODGR HEALTH PLAN (HSA) RESA BOX CLING (ROW) OTHER

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY EMP FROM TO QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NAME 17b. ADDRESS 17c. CITY STATE ZIP

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. PROVIDER NUCC USE

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

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH# ()

SIGNED DATE

Line Item 18

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

FROM MM DD YY TO MM DD YY

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

Line Item 19

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

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

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

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

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

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

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

8. CITY _____ STATE _____

9. ZIP CODE _____ TELEPHONE (Include Area Code) _____

10. INSURED'S POLICY OR GROUP OR FECA NUMBER _____

11. INSURED'S DATE OF BIRTH (MM/DD/YY) _____ SEX (M/F) _____

12. OTHER CLAIM ID (Designated by NUCC) _____

13. INSURANCE PLAN NAME OR PROGRAM NAME _____

14. CLAIM CODES (Designated by NUCC) _____

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) _____

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

17. DATE (MM/DD/YY) _____

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

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

20. OUTSIDE LAB? (Yes/No) _____

21. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

22. PRIOR AUTHORIZATION NUMBER _____

23. DATES OF SERVICE (From/To) (MM/DD/YY) _____

24. PROCEDURE, SERVICE OR SUPPLY (Specify Usual Circumstances) _____

25. DIAGNOSIS MONITOR _____

26. CHARGE _____

27. AMOUNT PAID _____

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) _____

29. SERVICE FACILITY LOCATION INFORMATION _____

30. BILLING PROVIDER INFO & PH# _____

31. SIGNATURE _____

32. DATE _____

33. NPI _____

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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

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
20	Outside Lab charges	2400	PS101	Purchased Service Provider ID	Required if there are diagnostic tests subject to the anti-markup payment price limits. 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 (NUCC) 02/22

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM 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 Spouse Other Other 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE 11. INSURED'S POLICY OR GROUP OR FECA NUMBER

12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 13. IS PATIENT'S CONDITION RELATED TO 14. EMPLOYMENT? (Current or Previous) YES NO 15. INSURED'S DATE OF BIRTH MM YY SEX M F

16. AUTO ACCIDENT? YES NO 17. PLACE (Work) YES NO 18. OTHER CLAIM ID (Designated by NUCC) 19. INSURANCE PLAN NAME OR PROGRAM NAME

20. CLAIM CODES (Designated by NUCC) 21. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO 22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment for services described below.)

SIGNED DATE 23. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO 24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

25. OUTSIDE LAB? YES NO 26. CHARGES 27. PHYSICIAN CODE ORIGINAL REF. NO. 28. PRIOR AUTHORIZATION NUMBER

29. DISEASES OR NATURE OF ILLNESS OR INJURY (Please list all conditions known) ICD-10 30. DATES OF SERVICE From To 31. PROCEDURE, SERVICE OR SUPPLY (Specify Usual Circumstances) CPT/HCPCS MODIFIER 32. DIAGNOSIS MONITOR 33. CHARGES 34. DATE OF BIRTH MM YY 35. NPI 36. RENDERING PROVIDER ID #

37. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 38. SERVICE FACILITY LOCATION INFORMATION 39. BILLING PROVIDER INFO & PH# 40. NPI 41. NPI

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

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (CHAMPVA) <input type="checkbox"/> GROUP HEALTH PLAN (GHP) <input type="checkbox"/> FECA BOXING (FECA BOXING) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)	
7. INSURED'S ADDRESS (No., Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		12. INSURED'S POLICY GROUP OR FECA NUMBER	
13. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) If yes, complete items 9, 10, and 11.		14. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment back.)		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. OUTSIDE LAB? (YES/NO) \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))		22. ORIGINAL REF. NO.	
23. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) PLACE OF SERVICE (SN) C. B. PROCEDURES, SERVICES, OR SUPPLIES (Specify Universal Circumstances) OPT/HCPCS MODIFIER		24. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) PLACE OF SERVICE (SN) C. B. PROCEDURES, SERVICES, OR SUPPLIES (Specify Universal Circumstances) OPT/HCPCS MODIFIER	
25. FEDERAL TAX I.D. NUMBER (SSN, EIN)		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (YES/NO) (No gov. benefit, per 401)		28. TOTAL CHARGE \$	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		30. AMOUNT PAID \$	
31. SERVICE FACILITY LOCATION INFORMATION		32. BILLING PROVIDER INFO & PH # ()	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER		34. PROVIDER NUCCL Use	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0038-1197 FORM 1700102-12



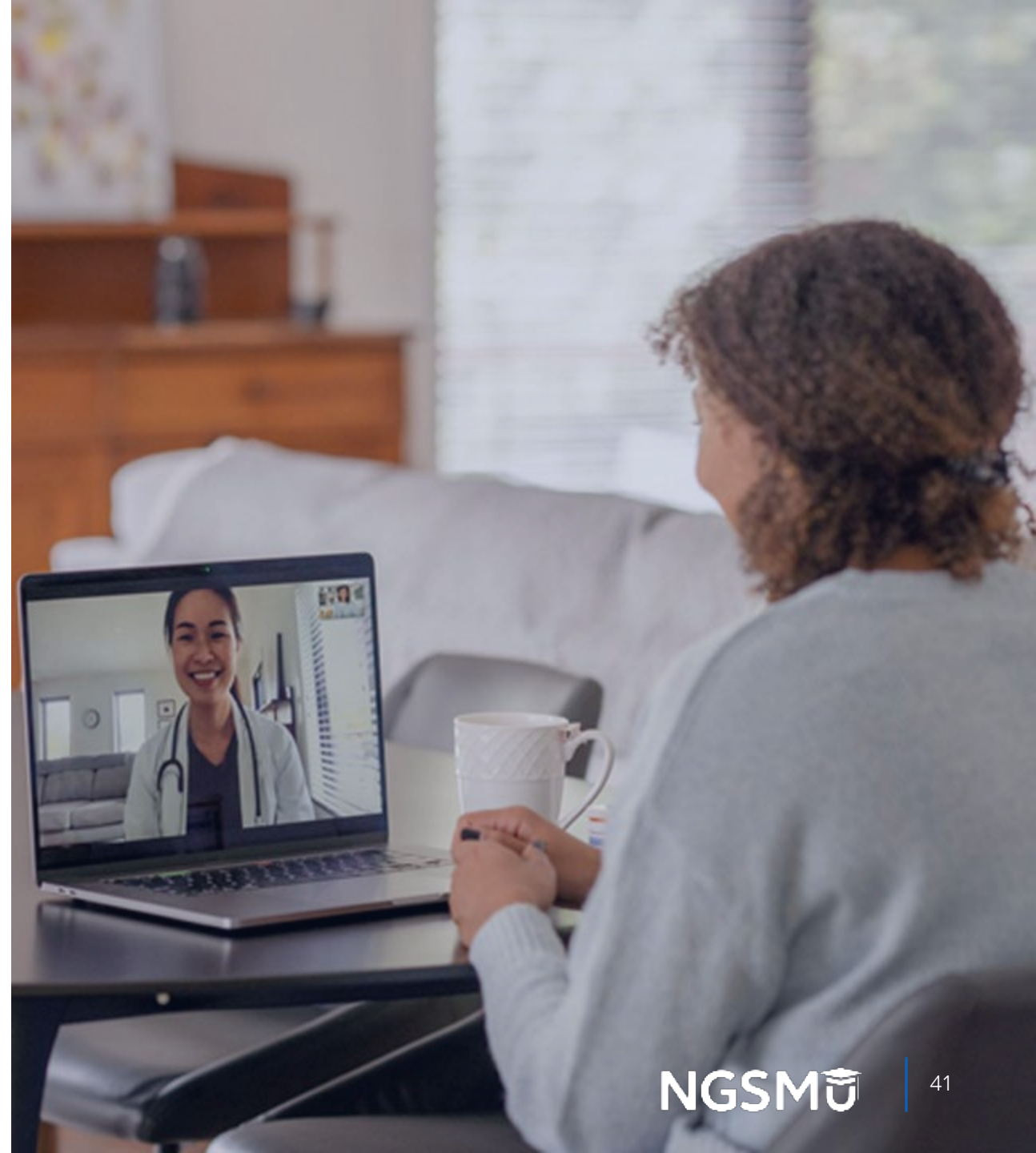
Line Item 21

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

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

EMC Equivalent Line 21

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





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHIP/PA (CHIP/PA) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BOX (FECA BOX) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		8. INSURED'S POLICY GROUP OR FECA NUMBER	
6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)		9. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
CITY STATE ZIP CODE TELEPHONE (Include Area Code)		10. OTHER CLAIM ID (Designated by NUCC)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO:		12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
a. EMPLOYMENT? (Current or Previous) YES NO		13. OTHER CLAIM ID (Designated by NUCC)	
b. AUTO ACCIDENT? YES NO PLACE (State)		14. INSURANCE PLAN NAME OR PROGRAM NAME	
c. OTHER ACCIDENT? YES NO		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 10, and 11	
11. INSURANCE PLAN NAME OR PROGRAM NAME		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assigned benefit.)	
12. CLAIM CODES (Designated by NUCC)		17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assigned benefit.)	
13. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL (Qual)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
14. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. OUTSIDE LAB? YES NO \$ CHARGES	
15. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL to codes and ICD-10)		21. PRIOR AUTHORIZATION NUMBER	
22. A. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Diagnose Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DATE OF SERVICE (MM/DD/YY) G. \$ CHARGES H. \$ CHARGES I. \$ CHARGES J. RENDERING PROVIDER ID #			
23. FEDERAL TAX ID NUMBER SSN EIN		24. PATIENT'S ACCOUNT NO.	
25. 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.)		26. SERVICE FACILITY LOCATION INFORMATION	
27. BILLING PROVIDER INFO & PH #		28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Provider NUCC Use	

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APPROVED CMB-0938-1197 FORM 1700102-12



Line Item 22

- Not required

22. RESUBMISSION CODE

ORIGINAL REF. NO.

- Not mapped electronically

Line Item 23

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

23. PRIOR AUTHORIZATION NUMBER

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

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare) ☐ MEDICAID (Medicaid) ☐ TRICARE (Tricare) ☐ CHAMPVA (Champion) ☐ GROUP HEALTH PLAN (Group Health Plan) ☐ OTHER (Other) ☐ 1a. INSURED'S I.D. NUMBER (For Programs 1-10)

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

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

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

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PATIENT'S CONDITION RELATED TO (a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? (c. OTHER ACCIDENT? (d. CLAIM CODES (Designated by NUCC)

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

PHYSICIAN OR SUPPLIER INFORMATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM/TO) 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO) 18. OUTSIDE LAB? (YES/NO) 19. RESUBMISSION CODE 20. ORIGINAL REF. NO. 21. PRIOR AUTHORIZATION NUMBER

BILLING INFORMATION

22. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM/DD/YY) QUAL (A/B/C/D/E) 23. NAME OF REFERRING PROVIDER OR OTHER SOURCE (NPI) 24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 25. DISEASES OR NATURE OF ILLNESS OR INJURY (ICD-10) 26. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS) 27. DIAGNOSIS MONITOR 28. TOTAL CHARGE 29. AMOUNT PAID 30. REMITTED TO NUCC USE

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

34. RECEIPTAL I.D. NUMBER 35. PATIENT'S ACCOUNT NO. 36. AGENT ASSIGNMENT? (YES/NO) 37. BILLING PROVIDER INFO & PH# ()

38. SIGNATURE OF PHYSICIAN OR SUPPLIER (DATE) 39. DATE 40. NPI 41. NPI 42. NPI 43. NPI 44. NPI 45. NPI 46. NPI 47. NPI 48. NPI 49. NPI 50. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 (FORM 1000-102-12) Clear Form



EMC Equivalent Line 23

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

Line Items 24A-24J

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

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DECA (JMW) OTHER (JMW) 14. INSURED'S I.D. NUMBER (For Programs 1 thru 11)

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

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

8. CITY STATE ZIP CODE TELEPHONE (Include Area Code) 9. INSURED'S CITY STATE ZIP CODE TELEPHONE (Include Area Code)

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 11. INSURED'S POLICY OR GROUP OR DECA NUMBER

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

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in as many as apply) 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From / To) B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) E. DIAGNOSIS F. G. H. I. J. RENDERING

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 26. SERVICE FACILITY LOCATION INFORMATION 27. BILLING PROVIDER INFO & PAYE ()

28. SIGNATURE DATE 29. SIGNATURE DATE 30. SIGNATURE DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 (FORM 10-01-12)



EMC Equivalent Lines 24A-24J

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

Line Item 25

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

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

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

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

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

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

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

CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR FECA NUMBER

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

SIGNED DATE 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM QUAL MM YY 15. OTHER DATE QUAL MM YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM YY TO MM YY

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Attach all to card on back of form) ICD-10 CODE 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 24. A. DATES OF SERVICE From MM YY To MM YY B. C. D. E. F. G. H. I. J. K. L. 25. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances or Modifiers) 26. DIAGNOSIS MONITOR 27. AMOUNT PAID 28. AMOUNT PAID 29. Fwd to NUCC Use

30. BILLING PROVIDER INFO & PH# 31. BILLING PROVIDER INFO & PH# 32. BILLING PROVIDER INFO & PH# 33. BILLING PROVIDER INFO & PH# 34. BILLING PROVIDER INFO & PH# 35. BILLING PROVIDER INFO & PH# 36. BILLING PROVIDER INFO & PH# 37. BILLING PROVIDER INFO & PH# 38. BILLING PROVIDER INFO & PH# 39. BILLING PROVIDER INFO & PH# 40. BILLING PROVIDER INFO & PH#

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1157 (FORM 100-102-12) Clear Form



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA DODDP HEALTH PLAN (HAP) FECA BOX CLING (FCM) OTHER (For Program in Item 1)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

14. OTHER CLAIM ID (Designated by NUCC)

15. INSURANCE PLAN NAME OR PROGRAM NAME

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES

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

22. PRIOR AUTHORIZATION NUMBER

23. BILLING PROVIDER INFO & PH # ()

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

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

34. NPI 35. NPI 36. NPI

Line Item 26

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

26. PATIENT'S ACCOUNT NO.

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



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (Tricare) <input type="checkbox"/> CHAMPVA (Champion's Children's Health and Medical Assistance Program) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		14. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
6. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other)		9. INSURED'S POLICY GROUP OR FECA NUMBER	
9. RESERVED FOR NUCC USE		10. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
10. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
11. RESERVED FOR NUCC USE		12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		13. INSURED'S POLICY GROUP OR FECA NUMBER	
13. INSURED'S POLICY GROUP OR FECA NUMBER		14. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
14. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		15. INSURED'S POLICY GROUP OR FECA NUMBER	
15. INSURED'S POLICY GROUP OR FECA NUMBER		16. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
16. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		17. INSURED'S POLICY GROUP OR FECA NUMBER	
17. INSURED'S POLICY GROUP OR FECA NUMBER		18. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
18. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		19. INSURED'S POLICY GROUP OR FECA NUMBER	
19. INSURED'S POLICY GROUP OR FECA NUMBER		20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
20. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		21. INSURED'S POLICY GROUP OR FECA NUMBER	
21. INSURED'S POLICY GROUP OR FECA NUMBER		22. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
22. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		23. INSURED'S POLICY GROUP OR FECA NUMBER	
23. INSURED'S POLICY GROUP OR FECA NUMBER		24. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
24. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		25. INSURED'S POLICY GROUP OR FECA NUMBER	
25. INSURED'S POLICY GROUP OR FECA NUMBER		26. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
26. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		27. INSURED'S POLICY GROUP OR FECA NUMBER	
27. INSURED'S POLICY GROUP OR FECA NUMBER		28. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
28. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		29. INSURED'S POLICY GROUP OR FECA NUMBER	
29. INSURED'S POLICY GROUP OR FECA NUMBER		30. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
30. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		31. INSURED'S POLICY GROUP OR FECA NUMBER	
31. INSURED'S POLICY GROUP OR FECA NUMBER		32. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
32. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		33. INSURED'S POLICY GROUP OR FECA NUMBER	
33. INSURED'S POLICY GROUP OR FECA NUMBER		34. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
34. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		35. INSURED'S POLICY GROUP OR FECA NUMBER	
35. INSURED'S POLICY GROUP OR FECA NUMBER		36. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
36. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		37. INSURED'S POLICY GROUP OR FECA NUMBER	
37. INSURED'S POLICY GROUP OR FECA NUMBER		38. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
38. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		39. INSURED'S POLICY GROUP OR FECA NUMBER	
39. INSURED'S POLICY GROUP OR FECA NUMBER		40. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
40. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		41. INSURED'S POLICY GROUP OR FECA NUMBER	
41. INSURED'S POLICY GROUP OR FECA NUMBER		42. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
42. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		43. INSURED'S POLICY GROUP OR FECA NUMBER	
43. INSURED'S POLICY GROUP OR FECA NUMBER		44. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
44. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		45. INSURED'S POLICY GROUP OR FECA NUMBER	
45. INSURED'S POLICY GROUP OR FECA NUMBER		46. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
46. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		47. INSURED'S POLICY GROUP OR FECA NUMBER	
47. INSURED'S POLICY GROUP OR FECA NUMBER		48. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
48. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		49. INSURED'S POLICY GROUP OR FECA NUMBER	
49. INSURED'S POLICY GROUP OR FECA NUMBER		50. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
50. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		51. INSURED'S POLICY GROUP OR FECA NUMBER	
51. INSURED'S POLICY GROUP OR FECA NUMBER		52. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
52. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		53. INSURED'S POLICY GROUP OR FECA NUMBER	
53. INSURED'S POLICY GROUP OR FECA NUMBER		54. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
54. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		55. INSURED'S POLICY GROUP OR FECA NUMBER	
55. INSURED'S POLICY GROUP OR FECA NUMBER		56. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
56. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		57. INSURED'S POLICY GROUP OR FECA NUMBER	
57. INSURED'S POLICY GROUP OR FECA NUMBER		58. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
58. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		59. INSURED'S POLICY GROUP OR FECA NUMBER	
59. INSURED'S POLICY GROUP OR FECA NUMBER		60. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
60. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		61. INSURED'S POLICY GROUP OR FECA NUMBER	
61. INSURED'S POLICY GROUP OR FECA NUMBER		62. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
62. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		63. INSURED'S POLICY GROUP OR FECA NUMBER	
63. INSURED'S POLICY GROUP OR FECA NUMBER		64. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
64. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		65. INSURED'S POLICY GROUP OR FECA NUMBER	
65. INSURED'S POLICY GROUP OR FECA NUMBER		66. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
66. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		67. INSURED'S POLICY GROUP OR FECA NUMBER	
67. INSURED'S POLICY GROUP OR FECA NUMBER		68. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
68. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		69. INSURED'S POLICY GROUP OR FECA NUMBER	
69. INSURED'S POLICY GROUP OR FECA NUMBER		70. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
70. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		71. INSURED'S POLICY GROUP OR FECA NUMBER	
71. INSURED'S POLICY GROUP OR FECA NUMBER		72. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
72. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		73. INSURED'S POLICY GROUP OR FECA NUMBER	
73. INSURED'S POLICY GROUP OR FECA NUMBER		74. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
74. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		75. INSURED'S POLICY GROUP OR FECA NUMBER	
75. INSURED'S POLICY GROUP OR FECA NUMBER		76. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
76. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		77. INSURED'S POLICY GROUP OR FECA NUMBER	
77. INSURED'S POLICY GROUP OR FECA NUMBER		78. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
78. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		79. INSURED'S POLICY GROUP OR FECA NUMBER	
79. INSURED'S POLICY GROUP OR FECA NUMBER		80. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
80. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		81. INSURED'S POLICY GROUP OR FECA NUMBER	
81. INSURED'S POLICY GROUP OR FECA NUMBER		82. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
82. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		83. INSURED'S POLICY GROUP OR FECA NUMBER	
83. INSURED'S POLICY GROUP OR FECA NUMBER		84. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
84. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		85. INSURED'S POLICY GROUP OR FECA NUMBER	
85. INSURED'S POLICY GROUP OR FECA NUMBER		86. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
86. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		87. INSURED'S POLICY GROUP OR FECA NUMBER	
87. INSURED'S POLICY GROUP OR FECA NUMBER		88. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
88. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		89. INSURED'S POLICY GROUP OR FECA NUMBER	
89. INSURED'S POLICY GROUP OR FECA NUMBER		90. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
90. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		91. INSURED'S POLICY GROUP OR FECA NUMBER	
91. INSURED'S POLICY GROUP OR FECA NUMBER		92. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
92. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		93. INSURED'S POLICY GROUP OR FECA NUMBER	
93. INSURED'S POLICY GROUP OR FECA NUMBER		94. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
94. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		95. INSURED'S POLICY GROUP OR FECA NUMBER	
95. INSURED'S POLICY GROUP OR FECA NUMBER		96. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
96. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		97. INSURED'S POLICY GROUP OR FECA NUMBER	
97. INSURED'S POLICY GROUP OR FECA NUMBER		98. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	
98. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)		99. INSURED'S POLICY GROUP OR FECA NUMBER	
99. INSURED'S POLICY GROUP OR FECA NUMBER		100. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)	

Line Item 27

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

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

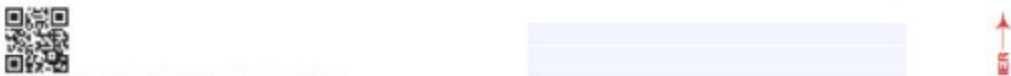
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

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

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

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

SIGNED **DATE**

PLEASE PRINT OR TYPE

APPROVED CMB-0938-1197 FORM 1700102-12

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Clear Form

Line Item 31

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

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

SIGNED **DATE**

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
30	Balance due	N301			
31	Signature of physician or supplier including degrees or credentials	2300	CLM06	Provider or supplier signature indicator	Y=Provider signature is on file N=Provider signature is not on file
	Date signed	N401			

Line Item 32

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

32. SERVICE FACILITY LOCATION INFORMATION	
a. NPI	b.

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

Line Items 32 and 32a

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

32. SERVICE FACILITY LOCATION INFORMATION

A. NPI

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

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

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

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

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

8. CITY STATE 9. RESERVED FOR NUCC USE 10. INSURED'S POLICY OR GROUP NUMBER

11. INSURED'S DATE OF BIRTH MM YY SEX 12. PATIENT'S CONDITION RELATED TO 13. INSURED'S POLICY OR GROUP NUMBER

14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 15. EMPLOYMENT? (Current or Previous) 16. INSURED'S DATE OF BIRTH MM YY SEX

17. OTHER INSURED'S POLICY OR GROUP NUMBER 18. AUTO ACCIDENT? YES NO 19. OTHER ACCIDENT? YES NO 20. OTHER CLAIM ID (Designated by NUCC)

21. INSURANCE PLAN NAME OR PROGRAM NAME 22. CLAIM CODES (Designated by NUCC) 23. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 19, 20, and 21

24. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY ONSET MM YY 25. OTHER DATE MM YY 26. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM YY TO MM YY

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

29. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 30. OUTSIDE LAB? YES NO 31. PRIOR AUTHORIZATION NUMBER

32. EXAMINER OR NATURE OF ILLNESS OR INJURY (Please fill in to complete block) 33. RESUBMISSION CODE 34. PRIOR AUTHORIZATION NUMBER

35. A. B. C. D. E. F. G. H. I. J. K. L. 36. DATES OF SERVICE From MM YY To MM YY 37. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual, Necessary, or Modest) 38. DIAGNOSIS MONITOR 39. CHARGES 40. DATE OF BIRTH MM YY 41. SEX 42. QUAL 43. RENDERING PROVIDER ID #

44. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) (I certify that the statement on this reverse applies to this bill and is made a part thereof.) 45. SERVICE FACILITY LOCATION INFORMATION 46. BILLING PROVIDER INFO & PH#

47. SIGNATURE DATE 48. NPI 49. NPI 50. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0935-1197 FORM 10-01-12 Clear Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02A2

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN (GHP) RESA BOXCLUNG OTHER

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

15. OTHER DATE (MM DD YY) QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. PROVIDER NUCC USE

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

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

33a. NPI

33b. NPI

Line Items 33 and 33a

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

33. BILLING PROVIDER INFO & PH # ()

a. NPI b.

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
33	Physician's supplier's billing name, address, zip code & phone number	2010AA or 2010AB	NM103 (B5)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
			NM104	Provider first name	NM101 Entity Identifier=87-Pay-to-provider
			NM105	Provider middle initial	
			N301	Provider address 1	NM102 Entity Type code 1 Person 2 Non-Person Entity
			N401	Provider city	
			N402	Provider state	Enter the provider or service/supplier's billing name, address, zip code and telephone number. Must be a physical address with nine-digit ZIP code.
			N403	Provider ZIP code	
			PER04	Provider phone number	
33a	NPI	2010AA	NM109 (B5)	Provider ID	NM101 Entity Identifier code=85-Billing Provider NM101 Entity Identifier code=87-Pay-to-provider Enter the NPI for the Group Number or for the performing provider of service/supplier who is a member of a group practice. Enter "XX" in the NM108 to indicate an NPI is present in the NM109
33b	Billing Taxonomy Number	2000A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PXC

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

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

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

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

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

Claim Rejection Reminders

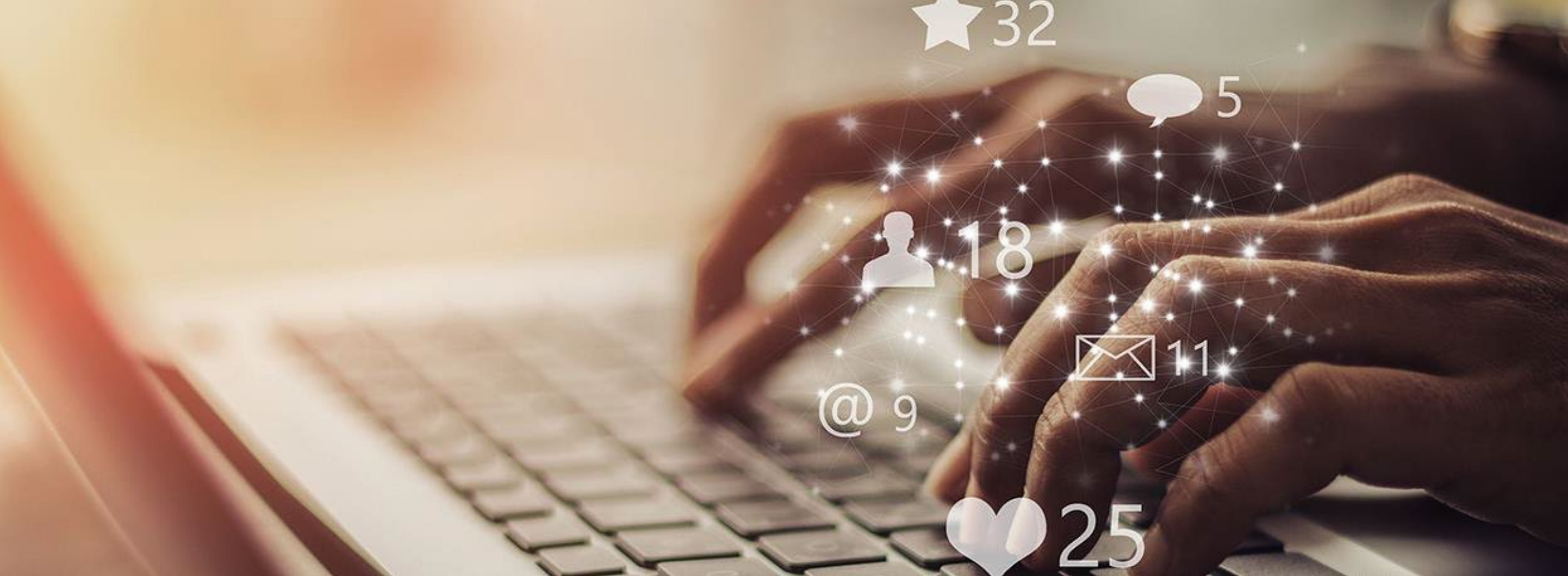
- Claim rejections CO16, MA130
 - Claims received that contain incomplete or invalid information will be “rejected” and returned as unprocessable
- Unprocessable claims have
 - No appeal rights
 - No reopening rights
- Resubmit a new claim with corrected information
- [Unprocessable Claim Rejections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

Resources and References

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

Questions?

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



Text NEWS to 37702; Text GAMES to 37702



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