

# Proper Medicare Part B Claim Submissions

8/30/2023

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

# Today's Presenters

## Provider Outreach and Education Consultants

- Arlene Dunphy, CPC
- Carleen Parker





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## 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

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

# 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 UNION CLAIM COMMITTEE JANUARY 2012

**PATIENT AND INSURER INFORMATION**

**1. PATIENT INFORMATION**

1.1. PATIENT'S NAME (Last Name, First Name, Middle Name)  
1.2. PATIENT'S DATE OF BIRTH (MM/DD/YYYY)  
1.3. PATIENT'S ADDRESS (Street, City, State, ZIP+4)

**2. INSURER INFORMATION**

2.1. INSURER'S NAME (Last Name, First Name, Middle Name)  
2.2. INSURER'S ADDRESS (Street, City, State, ZIP+4)  
2.3. INSURER'S POLICY GROUP OR PLAN NUMBER

**3. PROVIDER INFORMATION**

3.1. PROVIDER'S NAME (Last Name, First Name, Middle Name)  
3.2. PROVIDER'S ADDRESS (Street, City, State, ZIP+4)  
3.3. PROVIDER'S TAX ID NUMBER

**4. SERVICE INFORMATION**

4.1. DATE OF SERVICE (MM/DD/YYYY)  
4.2. PLACE OF SERVICE (Inpatient, Outpatient, etc.)  
4.3. SERVICE CODES (ICD-9-CM, CPT, HCPCS, etc.)

**5. PAYMENT INFORMATION**

5.1. AMOUNT BILLED (Total Charges)  
5.2. AMOUNT PAID (Insurance Payment)  
5.3. AMOUNT DUE (Patient Responsibility)

**6. SIGNATURES**

6.1. PROVIDER SIGNATURE  
6.2. PATIENT SIGNATURE  
6.3. AUTHORIZED REPRESENTATIVE SIGNATURE

Beneficiary  
data

Provider  
data





# NUCC Approved OMB

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

# Line Item 1

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE NUCC (2/12)

PATIENT AND INSURED INFORMATION										PAYER AND INSURED INFORMATION									
1. PATIENT'S NAME (Last name, first name, middle initial)										2. INSURED'S NAME (Last name, first name, middle initial)									
3. PATIENT'S ADDRESS (St., Apt.)										4. INSURED'S ADDRESS (St., Apt.)									
5. CITY STATE ZIP CODE TELEPHONE (include area code)										6. CITY STATE ZIP CODE TELEPHONE (include area code)									
7. OTHER INSURED'S NAME (Last name, first name, middle initial)										8. OTHER INSURED'S POLICY GROUP OR PLAN NUMBER									
9. OTHER INSURED'S POLICY OR GROUP NUMBER										10. OTHER INSURED'S DATE OF BIRTH									
11. REFERRED FOR NUCC USE										12. OTHER CLASS (Designated by NUCC)									
13. REFERRED FOR NUCC USE										13. INSURANCE PLAN NAME OR PROGRAM NAME									
14. INSURANCE PLAN NAME OR PROGRAM NAME										15. IS THERE ANOTHER HEALTH-BENEFIT PLAN?									
16. READ BACK OF FORM (SEE OTHER SIDE) AND SIGNATURE (SEE 10)										17. AUTHORIZED OR AUTHORIZED PERSONS SIGNATURE (I authorize payment of medical benefits to the undersigned provider or supplier for services described below)									
18. OTHER CLASS (Designated by NUCC)										19. OTHER CLASS (Designated by NUCC)									
20. DATE OF CURRENT CLAIM (Month, Day, Year)										21. DATE CLAIMABLE TO WORK IN CURRENT OCCUPATION									
22. NAME OF REFERRING PROVIDER OR OTHER SOURCE										23. HOSPITAL/CATION DATES RELATED TO CURRENT SERVICES									
24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										25. OUTPATIENT LUMP SUM CHARGES									
26. DATE OF SERVICE										27. REFERENCE NO.									
28. PROVIDER'S SERVICE OR SUPPLIES										29. PROVIDER'S SIGNATURE									
30. PROVIDER'S LOCATION INFORMATION										31. TOTAL CHARGE									
32. SERVICE FACILITY LOCATION INFORMATION										33. AMOUNT PAID									
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- 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)
- Lowercase letters will be converted 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)

# Line Item 2

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUPCC) 001

**PATIENT AND INSURED INFORMATION**

1. MEDICARE MEDICAID MEDICARE CHAMPVA OTHER 14. INSURED'S ID NUMBER (For Program in Item 1)

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

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

7. INSURED'S POLICY GROUP OR PLAN NUMBER 8. INSURED'S DATE OF BIRTH MM DD YY SEX M F 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR PLAN NUMBER

12. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (Authorized person's signature is required for payment of medical benefits to the undersigned physician or supplier for services described below)

13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE (Authorized person's signature is required for payment of medical benefits to the undersigned physician or supplier for services described below)

14. DATE OF CURRENT CLAIM (Injury or Pregnancy Claim) 15. OTHER DATE 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 NUPCC) 20. OUTSIDE LAB? YES NO \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes) ICD-9-CM CODE 22. SUBMISSION CODE Original Ref. No. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM MM DD YY TO MM DD YY B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 25. TOTAL CHARGE \$ 26. AMOUNT PAID \$ 27. PATIENT'S ACCOUNT NO. 28. SERVICE FACILITY LOCATION INFORMATION 29. BILLING PROVIDER INFO & P# 30. PATIENT'S MIDDLE INITIAL

31. SIGNATURE OF PATIENT OR SUPPLIER (Include address of claimant if different from above) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P# 34. PATIENT'S MIDDLE INITIAL

PLEASE PRINT OR TYPE

- 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.)	



- Patient's eight-digit date of birth (MMDDCCYY) and check the appropriate box for patient's sex

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
3	Patient's Birth Date and gender	2010BA	DMG02 DMG03	Birth Date Gender	Enter the patient's birth date. Must be formatted as CCYYMMDD Date qualifier (DMG01) = D8



# 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	

The image shows a full Health Insurance Claim Form (NUCC 0102). Key sections include:

- PATIENT AND INSURED INFORMATION:** Contains fields for patient name, address, birth date, sex, and insurance details. Item 4, 'INSURED'S NAME', is highlighted in blue.
- PHYSICIAN OR SUPPLIER INFORMATION:** Contains fields for provider name, address, and contact information.
- CLAIM INFORMATION:** Includes fields for claim number, date of service, and place of service.

# 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

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

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	

# Line Item 6

The image shows the front of a Health Insurance Claim Form (NUCC-012). The form is divided into several sections. The top section is for 'PATIENT AND INSURED INFORMATION'. The middle section is for 'PHYSICIAN OR SUPPLIER INFORMATION'. The bottom section is for 'BILLING INFORMATION'. A red box highlights the 'PATIENT RELATIONSHIP TO INSURED' section, which includes fields for 'Self', 'Spouse', 'Child', and 'Other'.

- 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	<b>Required when MSP is involved</b> 01 Spouse 18 Self 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship	



# Line Item 7

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

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 2D10BA 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	

# Line Item 8

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/02

PATIENT INFORMATION										PATIENT AND INSURED INFORMATION									
1. PATIENT'S NAME (Last, First Name, Middle Initial)										2. INSURED'S NAME (Last, First Name, Middle Initial)									
3. PATIENT'S ADDRESS (Include Area Code)										4. INSURED'S ADDRESS (Include Area Code)									
5. PATIENT'S POLICY OR GROUP NUMBER										6. INSURED'S POLICY OR GROUP NUMBER									
7. PATIENT'S DATE OF BIRTH										8. INSURED'S DATE OF BIRTH									
9. PATIENT'S SEX										10. INSURED'S SEX									
11. PATIENT'S EMPLOYMENT (Current or Previous)										12. INSURED'S EMPLOYMENT (Current or Previous)									
13. PATIENT'S OCCUPATION										14. INSURED'S OCCUPATION									
15. PATIENT'S SOCIAL SECURITY NUMBER										16. INSURED'S SOCIAL SECURITY NUMBER									
17. PATIENT'S SIGNATURE										18. INSURED'S SIGNATURE									
19. PATIENT'S DATE										20. INSURED'S DATE									
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NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED CLAIMS 11/07 (F) 11/07 (S) 12/07 (S)

- 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

# EMC Equivalent Lines 9, 9a-9d

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
9*	Other insured's Name (Last, First, Middle Initial)	2330A	NM103	Other insured last name	Name of insured for Medigap plan
			NM104	Other insured first name	
			NM105	Other insured middle name	
9a*	Other insured's policy or group number (Medigap only)	2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
			NM109	Other insured identifier	Medigap: P Primary S Secondary T Tertiary
		2320	SBP01	Payer responsibility	
			SBP03	Insured group or policy number	Enter the insured's group or plan number
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	2330B	N401	Other payer city name	Enter the city, state and ZIP code of the insurer. Required if any other payers are known to potentially be involved in paying this claim.
			N402	Other payer state code	
			N403	Other payer ZIP code	
9d*	Insurance plan name or program name	2330C	NM106	Other payer identification Code Qualifier	Medigap plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	



# Line Items 10a, 10b, and 10c

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

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

# Line Item 10d

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

## 10d. CLAIM CODES (Designated by NUCC)

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 01/02

**10d. CLAIM CODES (Designated by NUCC)**

A	B	C	D
1			
2			
3			
4			
5			
6			

PLEASE PRINT OR TYPE

# Line Items 11, 11a-11d

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0102

**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.

- 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

<b>11. INSURED'S POLICY GROUP OR FECA NUMBER</b>	
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 Line 11

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
11*	Insured policy group or FECA number	2320 or 2000B	SBR01	Payer responsibility P = Primary S = Secondary T = Tertiary <b>*Note:</b> If Medicare is Primary, use letter "P" and skip to item 12.	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to potentially be involved in paying this claim.
		2320	SBRO3	Insured Group or Policy Number	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	
			NM109	Insured's identifier	
		2000B or 2320	SBR05	Insurance Type Code	
				Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"	
				CLM01	
				CLM02	
		2300	CLM01	Claim submitter's identifier	
				Monetary amount	
		2320	AMT01	Amount qualifier code = D	
				Monetary amount (Primary Paid Claim Level)	
		2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)	
			CAS02	Claim adjustment reason codes	
			CAS03	Adjustment amount	
			CAS04	Adjustment quantity	
2330B or 2430			DTP01	Primary insurance adjudication date	
			DTP02	Date time period qualifier	
			DTP03	Date paid	





# EMC Equivalent Lines 11, 11a,-11c

- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

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



# 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 \_\_\_\_\_

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

# 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) 0012

**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 \_\_\_\_\_



# Line Item 14

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

**PATIENT AND INSURED INFORMATION**

1. MEDICARE MEDICAID TRICARE CHAMPVA SEVERE INJURY PLAN (SIP) 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'S RELATIONSHIP TO INSURED (Self | Spouse | Child | Other)

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

8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR PECA NUMBER

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

13. OTHER CLAIM ID (Designated by NUCC)

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

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

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

17. HOSPITAL ADMISSION DATES RELATED TO CURRENT SERVICES (FROM | TO) (MM | DD | YY | MM | DD | YY)

18. OUTPATIENT (YES | NO) \$ CHARGES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. PRESCRIPTION CODE ORIGINAL REF. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide all to service line below) (ICD-10)

22. PROK AUTHORIZATION NUMBER

23. A. DATES OF SERVICE (From | To) (MM | DD | YY | MM | DD | YY) B. CPT/HCPCS PROCESSES C. CHARGES D. CHARGES E. CHARGES F. CHARGES G. CHARGES H. CHARGES I. CHARGES J. CHARGES K. CHARGES L. CHARGES M. CHARGES N. CHARGES O. CHARGES P. CHARGES Q. CHARGES R. CHARGES S. CHARGES T. CHARGES U. CHARGES V. CHARGES W. CHARGES X. CHARGES Y. CHARGES Z. CHARGES

24. FEDERAL TAX ID NUMBER (SSN EIN) 25. PATIENT'S ACCOUNT NO. 26. AGENT'S SIGNATURE (YES | NO) 27. TOTAL CHARGE 28. AMOUNT PAID 29. REMAINING BALANCE

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials if certifying the statements on this form apply to the bill and make a part thereof) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO (PH#)

PLEASE PRINT OR TYPE

- 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) 0022

**PATIENT AND INSURED INFORMATION**

1. MEDICARE MEDICAID PRIVATE OTHER 14. INSURED'S ID NUMBER (for Program in Item 1)

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

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

CITY STATE 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 (Event or Preexisting) b. AUTO ACCIDENT c. OTHER ACCIDENT 10. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F) 11. INSURED'S POLICY GROUP OR PLAN 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 of benefits.) 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 of benefits.)

**PATIENT AND SUPPLIER INFORMATION**

14. DATE OF CURRENT CLAIM (Event or Preexisting) 15. DATE OF CLAIM (Event or Preexisting) 16. DATE OF CLAIM (Event or Preexisting)

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

19. OUTSIDE LAB 20. OUTSIDE LAB 21. OUTSIDE LAB

22. PERMANENT CODE 23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. TOTAL CHARGE 28. TOTAL PAID 29. OTHER CHARGE 30. OTHER PAID 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the statements on this form are true and are made a part of the record)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO (Print Name)

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED CLAIM 0022 1101 F0000 1001 101 102 Clear Form

# Line Item 16

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0242

1. MEDICARE MEDICAID WORKERS COMPENSATION GROUP HEALTH PLAN OTHER 14. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 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 ZIP CODE TELEPHONE (Include Area Code) 9. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR FICA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 13. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 14. INSURED'S POLICY GROUP OR FICA NUMBER

15. DATE OF CURRENT ILLNESS INJURY OR PREVENTIVE CARE 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. OUTSIDE LAB? 19. CHARGES 20. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to mark the ICD-9-CM) 22. PERMANENT CODE 23. ORIGINAL REP. NO.

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

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. TOTAL CHARGE 28. AMOUNT PAID 29. AMOUNT DUE 30. PAY BY DATE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# 34. BILLING PROVIDER ID#

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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CLAIM 0005-1107 (F000) 1000 (05/12)

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

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

FROM MM DD YY TO MM DD YY

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

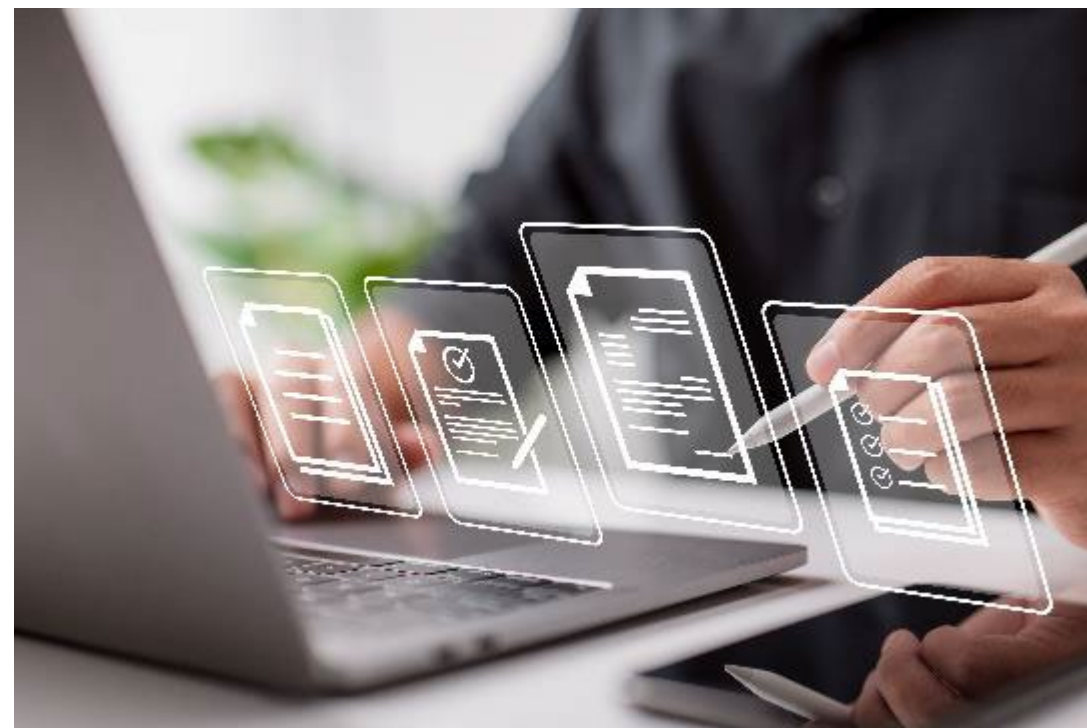
# Line Items 17 and 17b

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

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

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





# HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION									
<div> <div> 1. MEDICINE (Medicaid) 2. MEDICARE (Medicaid) 3. THICARE (Medicaid) 4. CHAMPA (Medicaid) 5. PATIENT'S BIRTH DATE MM / DD / YY 6. PATIENT RELATIONSHIP TO INSURED Spouse, Child, Other 7. INSURED'S NAME (Last Name, First Name, Middle Initial) 8. INSURED'S ADDRESS (No. Street) 9. CITY 10. STATE 11. ZIP CODE 12. TELEPHONE (Include Area Code) 13. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 14. OTHER INSURED'S POLICY OR GROUP NUMBER 15. RESERVED FOR NUCC USE 16. RESERVED FOR NUCC USE 17. RESERVED FOR NUCC USE 18. INSURANCE PLAN NAME OR PROGRAM NAME </div> <div> 19. PATIENT'S BIRTH DATE MM / DD / YY 20. PATIENT RELATIONSHIP TO INSURED Spouse, Child, Other 21. INSURED'S NAME (Last Name, First Name, Middle Initial) 22. INSURED'S ADDRESS (No. Street) 23. CITY 24. STATE 25. ZIP CODE 26. TELEPHONE (Include Area Code) 27. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 28. OTHER INSURED'S POLICY OR GROUP NUMBER 29. RESERVED FOR NUCC USE 30. RESERVED FOR NUCC USE 31. RESERVED FOR NUCC USE 32. INSURANCE PLAN NAME OR PROGRAM NAME </div> </div>									
<div> <div> 19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY STARTS MM / DD / YY 20. NAME OF REFERRING PROVIDER OR OTHER SOURCE 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Female A-L or Male H-S (See 401) 23. DATES OF SERVICE From MM / DD / YY To MM / DD / YY 24. PLACE OF SERVICE 25. PROCEDURE, SERVICE, OR SUPPLY (Specify Exact Description) 26. DIAGNOSIS (ICD-9) 27. ACCOUNT ASSIGNMENT (NUCC 1001) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BILLING PROVIDER INFO (Ph #) </div> <div> 29. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY STARTS MM / DD / YY 30. NAME OF REFERRING PROVIDER OR OTHER SOURCE 31. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Female A-L or Male H-S (See 401) 33. DATES OF SERVICE From MM / DD / YY To MM / DD / YY 34. PLACE OF SERVICE 35. PROCEDURE, SERVICE, OR SUPPLY (Specify Exact Description) 36. DIAGNOSIS (ICD-9) 37. ACCOUNT ASSIGNMENT (NUCC 1001) 38. TOTAL CHARGE 39. AMOUNT PAID 40. BILLING PROVIDER INFO (Ph #) </div> </div>									
<div> <div> 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If the claimant is the provider, apply to this box and make a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO (Ph #) </div> <div> 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If the claimant is the provider, apply to this box and make a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO (Ph #) </div> </div>									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROPRIATE CARS 1005-1197 (7/2002) 100122-126

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

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

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)

# 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

<b>20. OUTSIDE LAB?</b>		<b>\$ CHARGES</b>
<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	



# Line Item 21

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

# EMC Equivalent Line 21

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



# Line Item 22

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 10/12

**PATIENT AND INSURED INFORMATION**

1. MEDICARE MEDICAID PRIVATE OTHER  
2. PATIENT'S NAME (Last name, first name, middle initial)  
3. PATIENT'S ADDRESS (No. Street)  
CITY STATE ZIP CODE  
4. INSURED'S NAME (Last name, first name, middle initial)  
5. INSURED'S ADDRESS (No. Street)  
CITY STATE ZIP CODE  
6. INSURED'S POLICY GROUP OR PLAN NUMBER  
7. INSURED'S DATE OF BIRTH  
8. INSURED'S POLICY GROUP OR PLAN NAME  
9. IS THERE ANOTHER HEALTH BENEFIT PLAN?  
10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE  
11. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM  
12. DATE OF OTHER CLAIM  
13. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
14. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
16. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  
17. OUTSIDE LAB  
18. RESUBMISSION CODE  
19. ORIGINAL REF. NO.  
20. PRIOR AUTHORIZATION NUMBER

**PHYSICIAN OR SUPPLIER INFORMATION**

21. SIGNATURE OF PHYSICIAN OR SUPPLIER  
22. SERVICE FACILITY LOCATION INFORMATION  
23. BILLING PROVIDER INFO & P#

**PROCEDURES, SERVICES, OR SUPPLIES**

LINE	DATE OF SERVICE	PROCEDURE CODE	DIAGNOSIS CODE	CHARGES	AMOUNT PAID	REVENUE PROVIDER D. #
1						
2						
3						
4						
5						
6						

24. FEDERAL TAX ID NUMBER  
25. PATIENT'S ACCOUNT NO.  
26. SIGNATURE OF PHYSICIAN OR SUPPLIER  
27. SERVICE FACILITY LOCATION INFORMATION  
28. BILLING PROVIDER INFO & P#

NUCC Instruction Manual available at: www.nucc.org

- Not required
- Not mapped electronically

22. RESUBMISSION CODE	ORIGINAL REF. NO.
-----------------------	-------------------

# 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

<b>23. PRIOR AUTHORIZATION NUMBER</b> _____
--

The image shows a full Health Insurance Claim Form (NUCC-002) with various sections for patient, provider, and insurance information. A blue box highlights the 'PRIOR AUTHORIZATION NUMBER' field, which is located in the 'PATIENT AND INSURED INFORMATION' section, specifically in the 'OTHER CLAIM INFORMATION' area. The form includes fields for patient name, address, date of birth, sex, insurance policy number, and provider information. The 'PRIOR AUTHORIZATION NUMBER' field is labeled '23. PRIOR AUTHORIZATION NUMBER' and is highlighted with a blue border.



# 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

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0010

**PATIENT AND INSURED INFORMATION**

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ OTHER ☐ 14. INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last name, First name, Middle initial) 3. PATIENT'S DATE OF BIRTH (MM/DD/YY) 4. INSURED'S NAME (Last name, First name, Middle initial)

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

8. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE 11. INSURED'S POLICY GROUP OR PLAN 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 acknowledge payment of government benefits other than Social Security to the party who assigns 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 (MM/DD/YY) 15. OTHER DATE (MM/DD/YY) 16. DATED PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MD, DO, NP, PT, etc.) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) (ICD-10) 22. RESUBMISSION CODE (ORIGINAL, RE-FILED, etc.)

23. PRIOR AUTHORIZATION NUMBER 24. A. DATE OF SERVICE B. C. D. PROCEDURE, SERVICE, OR SUPPLY E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

25. FEDERAL TAX ID NUMBER (SSN, EIN, etc.) 26. PATIENT'S ACCOUNT NO. 27. AMOUNT PAID BY INSURED 28. TOTAL CHARGE 29. AMOUNT PAID 30. REMAINING NUCC USE

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

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED CLAIM CODES 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200 1201 1202 1203 1204 1205 1206 1207 1208 1209 1210 1211 1212 1213 1214 1215 1216 1217 1218 1219 1220 1221 1222 1223 1224 1225 1226 1227 1228 1229 1230 1231 1232 1233 1234 1235 1236 1237 1238 1239 1240 1241 1242 1243 1244 1245 1246 1247 1248 1249 1250 1251 1252 1253 1254 1255 1256 1257 1258 1259 1260 1261 1262 1263 1264 1265 1266 1267 1268 1269 1270 1271 1272 1273 1274 1275 1276 1277 1278 1279 1280 1281 1282 1283 1284 1285 1286 1287 1288 1289 1290 1291 1292 1293 1294 1295 1296 1297 1298 1299 1300 1301 1302 1303 1304 1305 1306 1307 1308 1309 1310 1311 1312 1313 1314 1315 1316 1317 1318 1319 1320 1321 1322 1323 1324 1325 1326 1327 1328 1329 1330 1331 1332 1333 1334 1335 1336 1337 1338 1339 1340 1341 1342 1343 1344 1345 1346 1347 1348 1349 1350 1351 1352 1353 1354 1355 1356 1357 1358 1359 1360 1361 1362 1363 1364 1365 1366 1367 1368 1369 1370 1371 1372 1373 1374 1375 1376 1377 1378 1379 1380 1381 1382 1383 1384 1385 1386 1387 1388 1389 1390 1391 1392 1393 1394 1395 1396 1397 1398 1399 1400 1401 1402 1403 1404 1405 1406 1407 1408 1409 1410 1411 1412 1413 1414 1415 1416 1417 1418 1419 1420 1421 1422 1423 1424 1425 1426 1427 1428 1429 1430 1431 1432 1433 1434 1435 1436 1437 1438 1439 1440 1441 1442 1443 1444 1445 1446 1447 1448 1449 1450 1451 1452 1453 1454 1455 1456 1457 1458 1459 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 1470 1471 1472 1473 1474 1475 1476 1477 1478 1479 1480 1481 1482 1483 1484 1485 1486 1487 1488 1489 1490 1491 1492 1493 1494 1495 1496 1497 1498 1499 1500 1501 1502 1503 1504 1505 1506 1507 1508 1509 1510 1511 1512 1513 1514 1515 1516 1517 1518 1519 1520 1521 1522 1523 1524 1525 1526 1527 1528 1529 1530 1531 1532 1533 1534 1535 1536 1537 1538 1539 1540 1541 1542 1543 1544 1545 1546 1547 1548 1549 1550 1551 1552 1553 1554 1555 1556 1557 1558 1559 1560 1561 1562 1563 1564 1565 1566 1567 1568 1569 1570 1571 1572 1573 1574 1575 1576 1577 1578 1579 1580 1581 1582 1583 1584 1585 1586 1587 1588 1589 1590 1591 1592 1593 1594 1595 1596 1597 1598 1599 1600 1601 1602 1603 1604 1605 1606 1607 1608 1609 1610 1611 1612 1613 1614 1615 1616 1617 1618 1619 1620 1621 1622 1623 1624 1625 1626 1627 1628 1629 1630 1631 1632 1633 1634 1635 1636 1637 1638 1639 1640 1641 1642 1643 1644 1645 1646 1647 1648 1649 1650 1651 1652 1653 1654 1655 1656 1657 1658 1659 1660 1661 1662 1663 1664 1665 1666 1667 1668 1669 1670 1671 1672 1673 1674 1675 1676 1677 1678 1679 1680 1681 1682 1683 1684 1685 1686 1687 1688 1689 1690 1691 1692 1693 1694 1695 1696 1697 1698 1699 1700 1701 1702 1703 1704 1705 1706 1707 1708 1709 1710 1711 1712 1713 1714 1715 1716 1717 1718 1719 1720 1721 1722 1723 1724 1725 1726 1727 1728 1729 1730 1731 1732 1733 1734 1735 1736 1737 1738 1739 1740 1741 1742 1743 1744 1745 1746 1747 1748 1749 1750 1751 1752 1753 1754 1755 1756 1757 1758 1759 1760 1761 1762 1763 1764 1765 1766 1767 1768 1769 1770 1771 1772 1773 1774 1775 1776 1777 1778 1779 1780 1781 1782 1783 1784 1785 1786 1787 1788 1789 1790 1791 1792 1793 1794 1795 1796 1797 1798 1799 1800 1801 1802 1803 1804 1805 1806 1807 1808 1809 1810 1811 1812 1813 1814 1815 1816 1817 1818 1819 1820 1821 1822 1823 1824 1825 1826 1827 1828 1829 1830 1831 1832 1833 1834 1835 1836 1837 1838 1839 1840 1841 1842 1843 1844 1845 1846 1847 1848 1849 1850 1851 1852 1853 1854 1855 1856 1857 1858 1859 1860 1861 1862 1863 1864 1865 1866 1867 1868 1869 1870 1871 1872 1873 1874 1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 2819 2820 2821 2822 2823 2824 2825 2826 2827 2828 2829 2830 2831 2832 2833 2834 2835 2836 2837 2838 2839 2840 2841 2842 2843 2844 2845 2846 2847 2848 2849 2850 2851 2852 2853 2854 2855 2856 2857 2858 2859 2860 2861 2862 2863 2864 2865 2866 2867 2868 2869 2870 2871 2872 2873 2874 2875 2876 2877 2878 2879 2880 2881 2882 2883 2884 2885 2886 2887 2888 2889 2890 2891 2892 2893 2894 2895 2896 2897 2898 2899 2900 2901 2902 2903 2904 2905 2906 2907 2908 2909 2910 2911 2912 2913 2914 2915 2916 2917 2918 2919 2920 2921 2922 2923 2924 2925 2926 2927 2928 2929 2930 2931 2932 2933 2934 2935 2936 2937 2938 2939 2940 2941 2942 2943 2944 2945 2946 2947 2948 2949 2950 2951 2952 2953 2954 2955 2956 2957 2958 2959 2960 2961 2962 2963 2964 2965 2966 2967 2968 2969 2970 2971 2972 2973 2974 2975 2976 2977 2978 2979 2980 2981 2982 2983 2984 2985 2986 2987 2988 2989 2990 2991 2992 2993 2994 2995 2996 2997 2998 2999 3000 3001 3002 3003 3004 3005 3006 3007 3008 3009 3010 3011 3012 3013 3014 3015 3016 3017 3018 3019 3020 3021 3022 3023 3024 3025 3026 3027 3028 3029 3030 3031 3032 3033 3034 3035 3036 3037 3038 3039 3040 3041 3042 3043 3044 3045 3046 3047 3048 3049 3050 3051 3052 3053 3054 3055 3056 3057 3058 3059 3060 3061 3062 3063 3064 3065 3066 3067 3068 3069 3070 3071 3072 3073 3074 3075 3076 3077 3078 3079 3080 3081 3082 3083 3084 3085 3086 3087 3088 3089 3090 3091 3092 3093 3094 3095 3096 3097 3098 3099 3100 3101 3102 3103 3104 3105 3106 3107 3108 3109 3110 3111 3112 3113 3114 3115 3116 3117 3118 3119 3120 3121 3122 3123 3124 3125 3126 3127 3128 3129 3130 3131 3132 3133 3134 3135 3136 3137 3138 3139 3140 3141 3142 3143 3144 3145 3146 3147 3148 3149 3150 3151 3152 3153 3154 3155 3156 3157 3158 3159 3160 3161 3162 3163 3164 3165 3166 3167 3168 3169 3170 3171 3172 3173 3174 3175 3176 3177 3178 3179 3180 3181 3182 3183 3184 3185 3186 3187 3188 3189 3190 3191 3192 3193 3194 3195 3196 3197 3198 3199 3200 3201 3202 3203 3204 3205 3206 3207 3208 3209 3210 3211 3212 3213 3214 3215 3216 3217 3218 3219 3220 3221 3222 3223 3224 3225 3226 3227 3228 3229 3230 3231 3232 3233 3234 3235 3236 3237 3238 3239 3240 3241 3242 3243 3244 3245 3246 3247 3248 3249 3250 3251 3252 3253 3254 3255 3256 3257 3258 3259 3260 3261 3262 3263 3264 3265 3266 3267 3268 3269 3270 3271 3272 3273 3274 3275 3276 3277 3278 3279 3280 3281 3282 3283 3284 3285 3286 3287 3288 3289 3290 3291 3292 3293 3294 3295 3296 3297 3298 3299 3300 3301 3302 3303 3304 3305 3306 3307 3308 3309 3310 3311 3312 3313 3314 3315 3316 3317 3318 3319 3320 3321 3322 3323 3324 3325 3326 3327 3328 3329 3330 3331 3332 3333 3334 3335 3336 3337 3338 3339 3340 3341 3342 3343 3344 3345 3346 3347 3348 3349 3350 3351 3352 3353 3354 3355 3356 3357 3358 3359 3360 3361 3362 3363 3364 3365 3366 3367 3368 3369 3370 3371 3372 3373 3374 3375 3376 3377 3378 3379

# 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 UNION CLAIM COMMITTEE (NUCC) 02/02

PATIENT										PATIENT AND INSURED INFORMATION																			
1. MEDICARE MEDICAID TRICARE CHAMPVA MEDICARE MEMBER BENEFIT PLAN OTHER (For Program in Step 1)										14. INSURED'S I.D. NUMBER (For Program in Step 1)																			
2. PATIENT'S NAME (Last name, First name, Middle initial)										4. INSURED'S NAME (Last name, First name, Middle initial)																			
3. POLICY GROUP NAME (MM YY) M F										7. INSURED'S ADDRESS (St., Street)																			
5. PATIENT'S ADDRESS (St., Street)										6. INSURED'S ADDRESS (St., Street)																			
8. CITY STATE										9. CITY STATE																			
10. ZIP CODE TELEPHONE (Include Area Code)										11. ZIP CODE TELEPHONE (Include Area Code)																			
12. OTHER INSURED'S NAME (Last name, First name, Middle initial)										13. IS PATIENT'S CONDITION RELATED TO:																			
15. OTHER INSURED'S POLICY OR GROUP NUMBER										16. INSURED'S POLICY GROUP OR OTHER NUMBER																			
17. RESERVED FOR NUCC USE										18. INSURED'S DATE OF BIRTH MM YY SEX M F																			
19. RESERVED FOR NUCC USE										20. OTHER CLAIM ID (Designated by NUCC)																			
21. INSURANCE PLAN NAME OR PROGRAM NAME										22. INSURANCE PLAN NAME OR PROGRAM NAME																			
23. CLAIM CODES (Designated by NUCC)										24. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, list plan name in Step 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 00																			
25. SIGNATURE OF AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I understand payment of government benefits will be subject to the party who accepts assignment benefit.)																													
26. DATE CURRENT CLAIM BEING FILED IN PRESENT CLAIM										27. OTHER DATE CLAIM BEING FILED IN PRESENT CLAIM																			
28. NAME OF REFERRING PROVIDER OR OTHER SOURCE										29. HOSPITAL CLINIC DATE(S) RELY TO CURRENT SERVICES																			
30. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										31. OUTSIDE LAB? YES NO CHARGES																			
32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please list service line below (SIC))										33. REFERRAL SOURCE ORIGINAL REF. NO.																			
34. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										35. PRIOR AUTHORIZATION NUMBER																			
36. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										37. REFERRING PROVIDER'S SIGNATURE																			
38. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										39. REFERRING PROVIDER'S I.D. #																			
40. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										41. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
42. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										43. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
44. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										45. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
46. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										47. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
48. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										49. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
50. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										51. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
52. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										53. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
54. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										55. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
56. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										57. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
58. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										59. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
60. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										61. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
62. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										63. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
64. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										65. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
66. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										67. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
68. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										69. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
69. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										70. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
70. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										71. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
71. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										72. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
72. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										73. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
73. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										74. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
74. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										75. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
75. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										76. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
76. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										77. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
77. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										78. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
78. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										79. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
79. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										80. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
80. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										81. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
81. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										82. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z																			
82. A B C D E																													



# 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.

# 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

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

☐ YES
☐ NO

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	CUM17	Assignment or Plan Participation code	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not assigned

# Line Items 28, 29 and 30

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

**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.

The image shows the front of a Health Insurance Claim Form (NUCC 0020). The form is divided into several sections: 
 

- Section 1:** MEDICARE, MEDICAID, PRIVATE, CHAMPVA, GROUP HEALTH PLAN, OTHER.
- Section 2:** PATIENT'S NAME (Last, First, Middle Initial), DATE OF BIRTH, SEX.
- Section 3:** PATIENT'S ADDRESS (No., Street, City, State, ZIP CODE), TELEPHONE (Include Area Code).
- Section 4:** INSURED'S NAME (Last, First, Middle Initial), DATE OF BIRTH, SEX.
- Section 5:** INSURED'S ADDRESS (No., Street, City, State, ZIP CODE), TELEPHONE (Include Area Code).
- Section 6:** EMPLOYMENT (Current or Previous), DATE OF BIRTH, SEX.
- Section 7:** INSURED'S POLICY (GROUP OR POLICY NUMBER), DATE OF BIRTH, SEX.
- Section 8:** INSURANCE PLAN NAME OR PROGRAM NAME, CLAIM CODE (Designated by NUCC).
- Section 9:** DATE OF CURRENT NUMBER INQUIRY OR FREQUENCY CLAIM, DATE OF BIRTH, SEX.
- Section 10:** NAME OF REFERRING PROVIDER OR OTHER SOURCE, DATE OF BIRTH, SEX.
- Section 11:** ADDITIONAL CLAIM INFORMATION (Designated by NUCC), DATE OF BIRTH, SEX.
- Section 12:** DATE OF SERVICE, PLACE OF SERVICE, PROCEDURE, SERVICE OR SUPPLY, CHARGE, REFERRING PROVIDER'S #.
- Section 13:** TOTAL CHARGE, AMOUNT PAID, REMAINING BALANCE.

 A blue box highlights the 'TOTAL CHARGE' field (Item 28) and the 'AMOUNT PAID' field (Item 29) in the bottom right section of the form.

# Line Item 31

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

**1. PATIENT INFORMATION**

1. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
2. PATIENT'S ADDRESS (No. & Apt)  
3. CITY  
4. STATE  
5. ZIP CODE  
6. TELEPHONE (Include Area Code)

**2. INSURER INFORMATION**

7. INSURER'S NAME (Last Name, First Name, Middle Initial)  
8. INSURER'S ADDRESS (No. & Apt)  
9. CITY  
10. STATE  
11. ZIP CODE  
12. TELEPHONE (Include Area Code)

**3. CLAIM INFORMATION**

13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM  
14. DATE OF OTHER DATE  
15. DATE OF OTHER DATE  
16. DATE OF OTHER DATE  
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Per AIC to be used for the claim)  
20. ICD-9-CM  
21. A. DATE OF SERVICE FROM  
22. B. DATE OF SERVICE TO  
23. C. PLACE OF SERVICE  
24. D. PROVIDER'S NAME  
25. E. PROVIDER'S ADDRESS  
26. F. PROVIDER'S CITY  
27. G. PROVIDER'S STATE  
28. H. PROVIDER'S ZIP CODE  
29. I. PROVIDER'S TELEPHONE  
30. J. PROVIDER'S FAX  
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#)

- 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



# Line Item 32

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

<b>32. SERVICE FACILITY LOCATION INFORMATION</b>	
a. <b>NPI</b>	b. <b> </b>

32	Name and address of facility where services were rendered (if other than home or office).	2310C	NM103 (77)	Laboratory or Service Facility Name	NM101 Entity Identifier code=77 - Service Location Required when the location of the service is different than that carried in 2010AA-Billing Provider (Item 32). Enter the name, address city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, and zip code. Required when the location of health care service is different than that carried in the Billing Provider Name (2010AB) 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	B.

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)		
		2400	PS101	Purchased service provider identifier	
		2420B	NM101	Identification code qualifier =QB	
		2300	NM108	Identification code=XX	
			NM109	Identification code	
			NM101	Identification code qualifier =QR	
			NM108	Identification code	
			NM109	Identification code	
		REF01		Reference Identification qualifier =EW	
		REF02		Mammogram FDA number	

# Line Items 33 and 33a

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

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
33	Physician's supplier's billing name, address, zip code & phone number	2010AA or 2010AB	NM103 (85)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
			NM104	Provider first name	NM101 Entity Identifier=87-Pay-to-provider
			NM105	Provider middle initial	
			N301	provider address 1	NM102 Entity Type code 1 Person 2 Non-Person Entity
			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 (85)	Provider ID	NM101 Entity Identifier code=85-Billing Provider NM101 Entity Identifier=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 NM106 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 <b>insured's</b> name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	



# Claim Rejection Reminders

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

# Resources 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.

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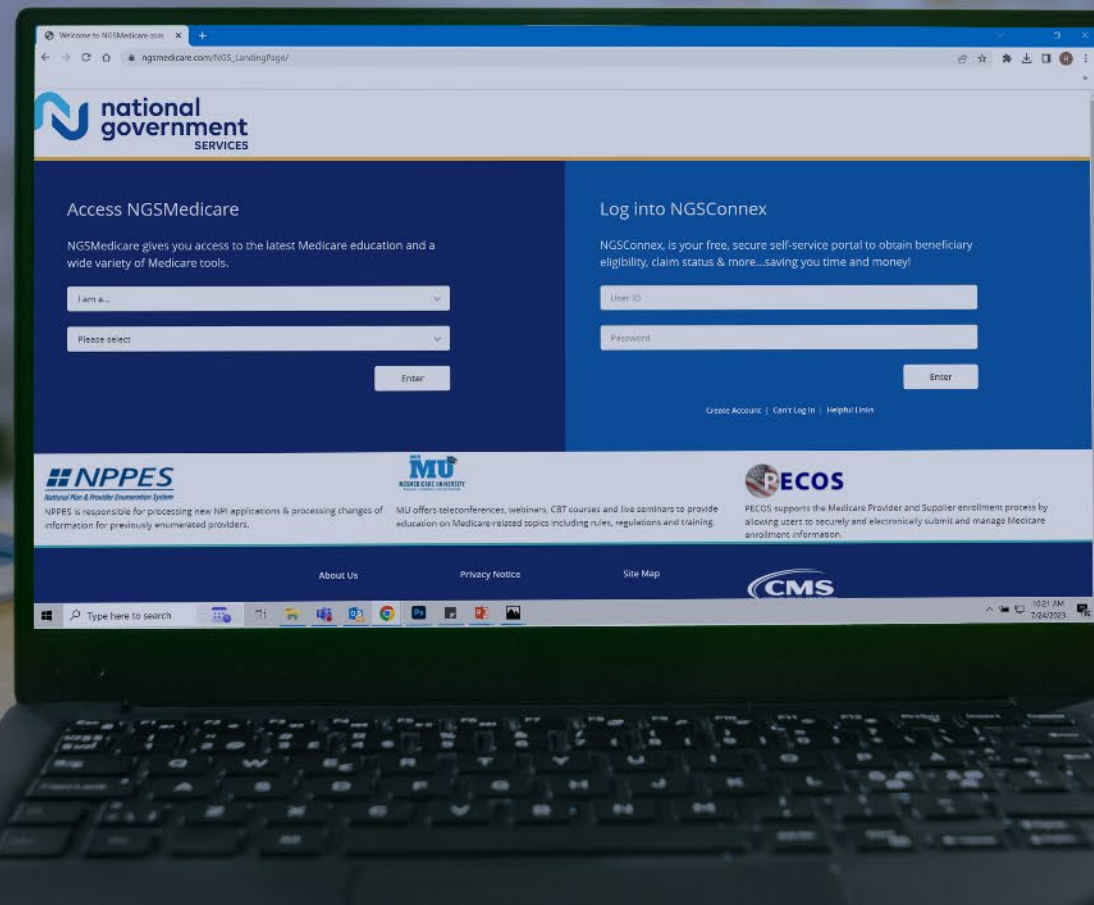
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