

Proper Medicare Part B Claim Submissions

12/19/2023

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



Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the [CMS website](#).



Recording

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

Objectives

After completion attendees will be able to

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



Agenda

Claim Form Requirements

Claims Filing Time Limit

Administrative Simplification

Compliance Act

Paper and Electronic Claim Overview

Resources, References and Tools

Claim Form Requirements

Claim Submission Requirements

- Paper
 - Original CMS-1500 Claim Form
 - 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)

Beneficiary data



Provider data



NUCC Approved OMB

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

1. PATIENT'S NAME (Last, First, Middle Initial)
2. PATIENT'S ADDRESS (Street, Apt. No., Box)
3. CITY, STATE, ZIP CODE
4. PATIENT'S DATE OF BIRTH (MM/DD/YYYY)
5. PATIENT'S SEX (M, F)
6. PATIENT'S RACE (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, Other)
7. PATIENT'S EMPLOYER (Name, Address, City, State, ZIP Code)
8. PATIENT'S POLICY NUMBER (Group, Individual)
9. PATIENT'S PLAN NAME (Group, Individual)
10. PATIENT'S ACCOUNT NUMBER (Group, Individual)
11. PATIENT'S ACCOUNT NUMBER (Group, Individual)
12. PATIENT'S ACCOUNT NUMBER (Group, Individual)

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

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

1. PATIENT'S NAME (Last, First, Middle Initial)
2. PATIENT'S ADDRESS (Street, Apt. No., Box)
3. CITY, STATE, ZIP CODE
4. PATIENT'S DATE OF BIRTH (MM/DD/YYYY)
5. PATIENT'S SEX (M, F)
6. PATIENT'S RACE (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, Other)
7. PATIENT'S EMPLOYER (Name, Address, City, State, ZIP Code)
8. PATIENT'S POLICY NUMBER (Group, Individual)
9. PATIENT'S PLAN NAME (Group, Individual)
10. PATIENT'S ACCOUNT NUMBER (Group, Individual)
11. PATIENT'S ACCOUNT NUMBER (Group, Individual)
12. PATIENT'S ACCOUNT NUMBER (Group, Individual)

Line Item 1

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

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

The image shows a scan of a Health Insurance Claim Form (Form 1099) with a red box highlighting the 'INSURED'S I.D. NUMBER' field. The form includes various sections for patient information, insurance details, and provider information.

Line Item 2

The image shows a standard Health Insurance Claim Form (Form 100-0) with a red box highlighting the patient's name field. The form includes sections for patient information, insurance details, and provider information. The highlighted area contains the patient's last name, first name, middle initial, and suffix.

- 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.)	

Line Item 3

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

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

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

The image shows a full Health Insurance Claim Form (NUPIC) with various sections for patient, insurance, and provider information. A red box highlights the birth date and sex fields, corresponding to the example form shown in the previous block.

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 the front of a Health Insurance Claim Form (HC-100). The form is titled 'HEALTH INSURANCE CLAIM FORM' and includes a QR code in the top left corner. The form is divided into several sections: 'PATIENT AND INSURED INFORMATION', 'PHYSICIAN OR SUPPLIER INFORMATION', and 'CARRIER'. The 'PATIENT AND INSURED INFORMATION' section includes fields for patient name, address, date of birth, sex, and insurance plan details. The 'PHYSICIAN OR SUPPLIER INFORMATION' section includes fields for provider name, address, and specialty. The 'CARRIER' section includes fields for carrier name and policy number. A red box highlights the 'INSURED'S NAME' field, which is labeled 'INSURED'S NAME (Last Name, First Name, Middle Initial)'. The form also includes checkboxes for 'MEDICARE' and 'MEDICAID' and a section for 'ADDITIONAL CLAIM INFORMATION'.

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 AUGUST 2012

1 MEDICARE MEDICAID PRIVATE CHARITY OTHER INSURANCE NUMBER (If Applicable)

2 RESPONSIBILITY (CHECK ONE) TO BE PAID BY

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

4 OTHER INSURED'S POLICY OR GROUP NUMBER

5 EMPLOYER'S CONDITION RELATED TO

6 INSURED'S POLICY OR POLICY NUMBER

7 EMPLOYER'S NAME (Print or Type) ADDRESS CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8 OTHER CLAIM ID (Designated by NCP)

9 INSURANCE PLAN NAME OR PROGRAM NAME

10 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print Name) DATE

11 DATE OF SERVICE (Month/Day/Year) TIME

12 PROVIDER'S SIGNATURE (Print Name) DATE

13 SERVICE FACILITY LOCATION INFORMATION

14 SERVICE PROVIDER IDENTIFICATION

Line Item 6

The image shows a scan of a Health Insurance Claim Form (HIC-900) with a red box highlighting the 'PATIENT RELATIONSHIP TO INSURED' section. The box contains the text 'Self', 'Spouse', 'Child', and 'Other' with corresponding checkboxes. The form is titled 'HEALTH INSURANCE CLAIM FORM' and includes various fields for patient and insured information.

- 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	

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

The image shows a standard Health Insurance Claim Form (NUCC 1000) with various sections for patient and insured information, claim details, and a table for procedure codes. A red box highlights the section at the bottom of the form, which is labeled '8. RESERVED FOR NUCC USE'.

- 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

The image shows a full Health Insurance Claim Form (NUCC-100) with a QR code in the top left corner. The form is titled 'HEALTH INSURANCE CLAIM FORM' and 'APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE IN ACCORDANCE WITH'. The form is divided into several sections: 'PATIENT AND INSURED INFORMATION', 'PATIENT OR SUPPLIER INFORMATION', and 'OTHER INFORMATION'. A blue box highlights the section for 'OTHER INSURED'S POLICY OR GROUP NUMBER' and 'INSURANCE PLAN NAME OR PROGRAM NAME'. The form includes fields for patient name, address, date of birth, sex, and insurance plan details. The bottom of the form has a section for 'OTHER INFORMATION' with fields for 'DATE OF SERVICE', 'PROCEDURES SERVICES OR SUPPLIES', 'BILLING INFORMATION', and 'BILLING PROVIDER INFO'. The form is labeled 'NUCC-100' and 'PLEASE PRINT OR TYPE'.

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	MM103	Other insured last name	Name of insured for Medigap plan
	MM104		Other insured first name		
	MM105		Other insured middle name		
9a*	Other insured's policy or group number (Medigap only)	2330A	MM108	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
			MM109	Other insured identifier	Medigap: P Primary S Secondary T Tertiary
		2330	SR001	Payer responsibility	Enter the insured's group or plan number
			SR003	Insured group or policy number	
9b*	Other insured's date of birth and sex				
9c	Employer's name or school name (Medigap Address)	2330B	N401	Other payer city name	Enter the city, state and ZIP code of the insurer. Required if any other payers are known to potentially be involved in paying this claim.
			N402	Other payer state code	
			N403	Other payer ZIP code	
9d*	Insurance plan name or program name	2330B	MM108	Other payer Identification Code Qualifier	Medigap plan only
			MM109	Payer last or organization name	
			MM103	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)

The image shows a scan of a Health Insurance Claim Form (NUCC) with a red box highlighting the 'CLAIM CODES' section. The form is titled 'HEALTH INSURANCE CLAIM FORM' and includes a QR code in the top left corner. The form is divided into several sections, including 'PATIENT AND INSURED INFORMATION', 'PHYSICIAN OR SUPPLIER INFORMATION', and 'CLAIM INFORMATION'. The 'CLAIM INFORMATION' section contains a table for 'CLAIM CODES' with columns for 'LINE ITEM', 'DATE OF SERVICE', 'ICD-9-CM CODE', 'CPT CODE', 'PROCEDURE, SERVICE OR SUPPLY', 'DIAGNOSIS', 'REASON FOR DENIAL', 'DATE OF DENIAL', and 'REVISION NUMBER'. The 'CLAIM CODES' section is highlighted with a red box, and the text '10d. CLAIM CODES (Designated by NUCC)' is written in red above it.

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	SEX
MM DD YY	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 <i>If yes, complete items 9, 9a and 9d.</i>

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 *Note: If Medicare is Primary, use letter "P" and skip to item 12.	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to potentially be involved in paying this claim.
		2320	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"	
		2300	CLM01	Claim submitter's identifier	
			CLM02	Monetary amount	
		2320	AMT01	Amount qualifier code = D	
			AMT02	Monetary amount (Primary Paid Claim Level)	
		2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)	
			CAS02	Claim adjustment reason codes	
			CAS03	Adjustment amount	
CAS04	Adjustment quantity				
2330B or 2430	DTP01	Primary insurance adjudication date			
	DTP02	Date time period qualifier			
	DTP03	Date paid			



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			
		2300 or 2400	CN102	OTAF amount				
			SVD01	Identification code				
		2430	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

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

The image shows a standard Health Insurance Claim Form (HC-90) with a blue box highlighting the date field in section 15. The form is divided into several sections: PATIENT AND INSURED INFORMATION, PATIENT OR SUPPLIER INFORMATION, and a table for line items. The date field in section 15 is labeled '15. OTHER DATE' and contains the fields 'QUAL', 'MM', 'DD', and 'YY'. The form also includes a QR code in the top left corner and a 'PLEASE PRINT OR TYPE' instruction at the bottom.

Line Item 16

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM MM | DD | YY TO MM | DD | YY

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

Line Items 17 and 17b

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNION OF CLAIM COMMITTEE EXECUTIVES

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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	



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)

The image shows a standard Health Insurance Claim Form (UB-04) with various sections. A red box highlights the 'ADDITIONAL CLAIM INFORMATION' section, which is designated by NUCC. The form includes a QR code, a barcode, and a 'PLEASE PRINT OR TYPE' instruction. The form is divided into sections for 'PATIENT AND INSURER INFORMATION' and 'PHYSICIAN OR SUPPLIER INFORMATION'. The 'ADDITIONAL CLAIM INFORMATION' section is located in the middle of the form, below the 'INSURER INFORMATION' section. The form also includes a table for line items at the bottom, with columns for 'LINE ITEM', 'DATE', 'ICD-9-CM', 'CPT', 'HCPCS', 'REASON FOR DENIAL', and 'REMARKS'. The 'ADDITIONAL CLAIM INFORMATION' section is highlighted in red, and the text '19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)' is written in red above it.

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	

The image shows a standard UB-04 Health Insurance Claim Form. The form is divided into several sections: 'PATIENT AND INSURER INFORMATION' at the top, 'PHYSICIAN OR SUPPLIER INFORMATION' at the bottom, and a central section for 'CLAIM INFORMATION'. The 'OUTSIDE LAB' field (2320) is highlighted with a blue box. The form includes fields for patient name, address, date of birth, sex, and insurance policy details. It also includes checkboxes for medical necessity and a section for physician or supplier information.

Line Item 21

The image shows a standard UB-04 Health Insurance Claim Form. A blue rectangular box highlights section 21, titled 'DIAGNOSIS OR NATURE OF ILLNESS OR INJURY'. This section contains a table with columns for 'ICD-10-CM' and 'ICD-9-CM' codes, and rows for up to 12 diagnosis entries. The form also includes various administrative fields such as patient name, address, insurance policy number, and provider information.

- 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

This is a close-up view of the UB-04 form section 21. It shows the table for entering diagnosis codes. The table has four columns labeled A, B, C, and D, and four rows labeled E, F, G, and H. To the right of the table is the 'ICD Ind.' field, which is highlighted with a blue arrow pointing to it. The instruction above the table reads: '21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)'. The ICD indicator field is currently empty.

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 01/01/2017

PATIENT AND INSURED INFORMATION

1. PATIENT'S NAME (Last, First, Middle Initial) _____
 2. PATIENT'S DATE OF BIRTH (MM/DD/YYYY) _____
 3. PATIENT'S SEX (M, F) _____
 4. PATIENT'S ADDRESS (St., Apt. #, City, State, Zip) _____
 5. PATIENT'S POLICY OR GROUP NUMBER _____
 6. EMPLOYER'S NAME (Include address) _____
 7. INSURER'S NAME (Last Name, Full Name, Address) _____
 8. INSURER'S ADDRESS (St., Apt. #, City, State, Zip) _____
 9. INSURER'S POLICY AND PRODUCT NUMBER _____
 10. INSURANCE PURCHASED BY (Insured Name) _____
 11. DATE OF CURRENT CLAIM (MM/DD/YYYY) _____
 12. DATE OF CURRENT CLAIM (MM/DD/YYYY) _____
 13. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE _____
 14. PHYSICIAN'S SPECIALTY (Related to Current Referral) _____
 15. ADDITIONAL CLAIM INFORMATION (Designated by NUBC) _____
 16. DATE OF SERVICE (MM/DD/YYYY) _____
 17. PHYSICIAN'S ACCOUNT NO. _____
 18. TOTAL CHARGE \$ _____
 19. AMOUNT PAID \$ _____
 20. REASON FOR DENIAL _____

PHYSICIAN OR SUPPLIER INFORMATION

LINE ITEM	ICD-9-CM PROCEDURE CODE	ICD-9-CM DIAGNOSIS CODE	UNIT	CHARGE	PAID	REASON FOR DENIAL
1						
2						
3						
4						
5						
6						

22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

PLEASE PRINT OR TYPE

- 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

23. PRIOR AUTHORIZATION NUMBER

The image shows a standard Health Insurance Claim Form (HC-100) with various sections for patient and insured information, dates, and provider details. A red box highlights the 'PRIOR AUTHORIZATION NUMBER' field in section 23. The form includes fields for patient name, address, date of birth, sex, and relationship to insured. It also includes fields for insured name, address, date of birth, sex, and relationship to patient. The form is divided into sections for 'PATIENT AND INSURED INFORMATION', 'DATE', and 'PROVIDER OR SUPPLIER INFORMATION'. The 'PRIOR AUTHORIZATION NUMBER' field is located in section 23, which is highlighted with a red box.

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)

LINE ITEM SECTION:

LINE NO.	DATE OF SERVICE	PROCESSED SERVICE OR SUPPLY	UNIT	UNIT PRICE	CHARGE	DISCOUNT	NET AMOUNT	PROVIDER USE ONLY
1								
2								
3								
4								
5								
6								

- 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

LINE NO.	DATE OF SERVICE	PROCESSED SERVICE OR SUPPLY	UNIT	UNIT PRICE	CHARGE	DISCOUNT	NET AMOUNT	PROVIDER USE ONLY
1								

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="checkbox"/> <input type="checkbox"/>

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

Line Item 26

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

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?
IF 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.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE IN NOVEMBER 2012

1 PATIENT'S OR AUTHORIZED PROVIDER'S SIGNATURE (Indicate the reason if any member of the authorized provider's family is providing the claim information as permitted government benefits other than support or to the party who accepts assignment.)

2 TOTAL CHARGE AMOUNT PAID (SEE INSTRUCTIONS)

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

Line Item 32

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

32. SERVICE FACILITY LOCATION INFORMATION	
a.	NPI
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

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	
		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 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.

Connect with us on Social Media



[YouTube Channel](#)

Educational Videos

medicare **mobile**

Text NEWS to 37702; Text GAMES to 37702



www.MedicareUniversity.com

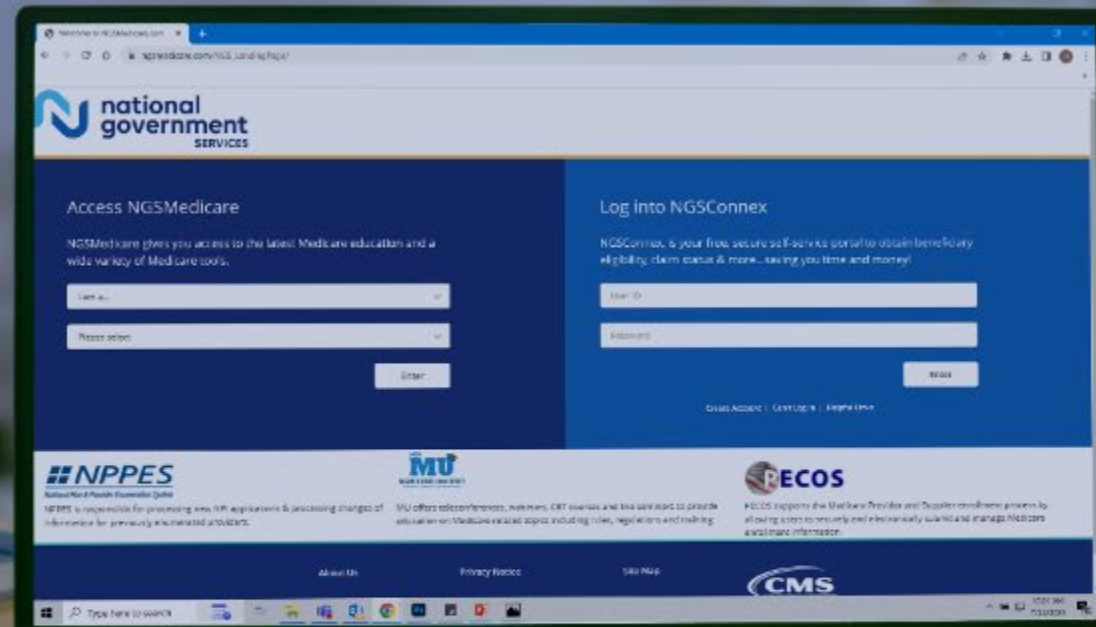
Self-paced online learning



[LinkedIn](#)

Educational Content

Find us online



www.NGS Medicare.com

Online resources, event calendar, LCD/NCD, and tools



IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



NGSConnex

Web portal for claim information



[Sign up for Email Updates](#)

Subscribe for Email updates at the top of any NGS Medicare.com webpage to stay informed of news