DME Providers-ACA Requirements for Ordering Providers

On February 28, 2017 an RA message was published to address the ACA requirement that DME (Durable Medical Equipment) providers include the ordering provider NPI number on claims submitted to Medicaid for reimbursement. This message is also available for review on the lamedicaid.com home page. Updated billing instructions to assist providers with meeting this requirement are being provided below for convenience (scroll down to view revised billing instructions). Updates to the billing instructions located in the DME service manual at lamedicaid.com are forthcoming. Questions regarding this message, the updated billing instructions, and/or fee for service claims should be directed to Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

March 2017

CMS 1500 (02/12) INSTRUCTIONS FOR DME SERVICES

You must write "DME" at the top center of the claim form!

Field/Item #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / ChampVA / Group Health Plan / FECA Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	**You must write "DME" at the top center of the Louisiana Medicaid claim form in LARGE letters.**
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Situational** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to	**Situational** – Complete if appropriate or leave blank.	

Field/Item #	Description	Instructions	Alerts
	Insured		
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Reserved For NUCC Use	**Leave Blank.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	**ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE CLAIMS**
9b	Reserved For NUCC Use	**Leave Blank.**	
9c	Reserved For NUCC Use	**Leave Blank.**	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
11b	Other Claim ID (Designated by NUCC)	**Leave Blank.**	

Field/Item #	Description	Instructions	Alerts
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	Other Date	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Required-** Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported. o DK Ordering Provider Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who ordered the service(s) or supply(ies) on the claim.	**For LA Medicaid other source is defined as the ordering provider. The ordering provider is required.**
17a	Other ID#	**Required –** Enter the 7-digit Medicaid ID number of the ordering provider.	
17b	NPI #	**Required -** Enter the NPI number of the ordering provider.	**The 10-digit NPI Number is required.**

Field/Item #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Additional Claim Information (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab?	**Optional.**	
21	ICD Ind. Diagnosis or Nature of Illness or Injury	**Required** – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM **Required** – Enter the most current ICD diagnosis code. **NOTE**: **ICD-9-CM Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.** **ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.**	The most specific diagnosis codes must be used. General codes are not acceptable. **ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.** **ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.** Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
22	Resubmission and/or Original Reference Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice	**To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.**

Field/Item #	Description	Instructions	Alerts
		in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	
23	Prior Authorization Number	**Required:** Enter the correct 9-digit Prior Authorization number in this field.	
24	Supplemental Information	**Situational – DME Providers are required to enter 11-digit NDC codes on claim detail lines for enteral feeding products only.** In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 and **<u>shall be entered</u>** in the **shaded** section of 24A through 24G. **<u>Claims for enteral feeding products must include the NDC from the label of the product administered.</u>** **<u>A list of the procedure codes and NDCs for products that currently require NDC information can be found on www.lamedicaid.com under the Fee Schedules directory link.</u>**	**DME providers must enter NDC information in the SHADED section of 24A – 24G of appropriate detail lines only.** **This information must be entered in addition to the procedure code(s).** **The NDC indicated on the claim must match the NDC on the Prior Authorization.**

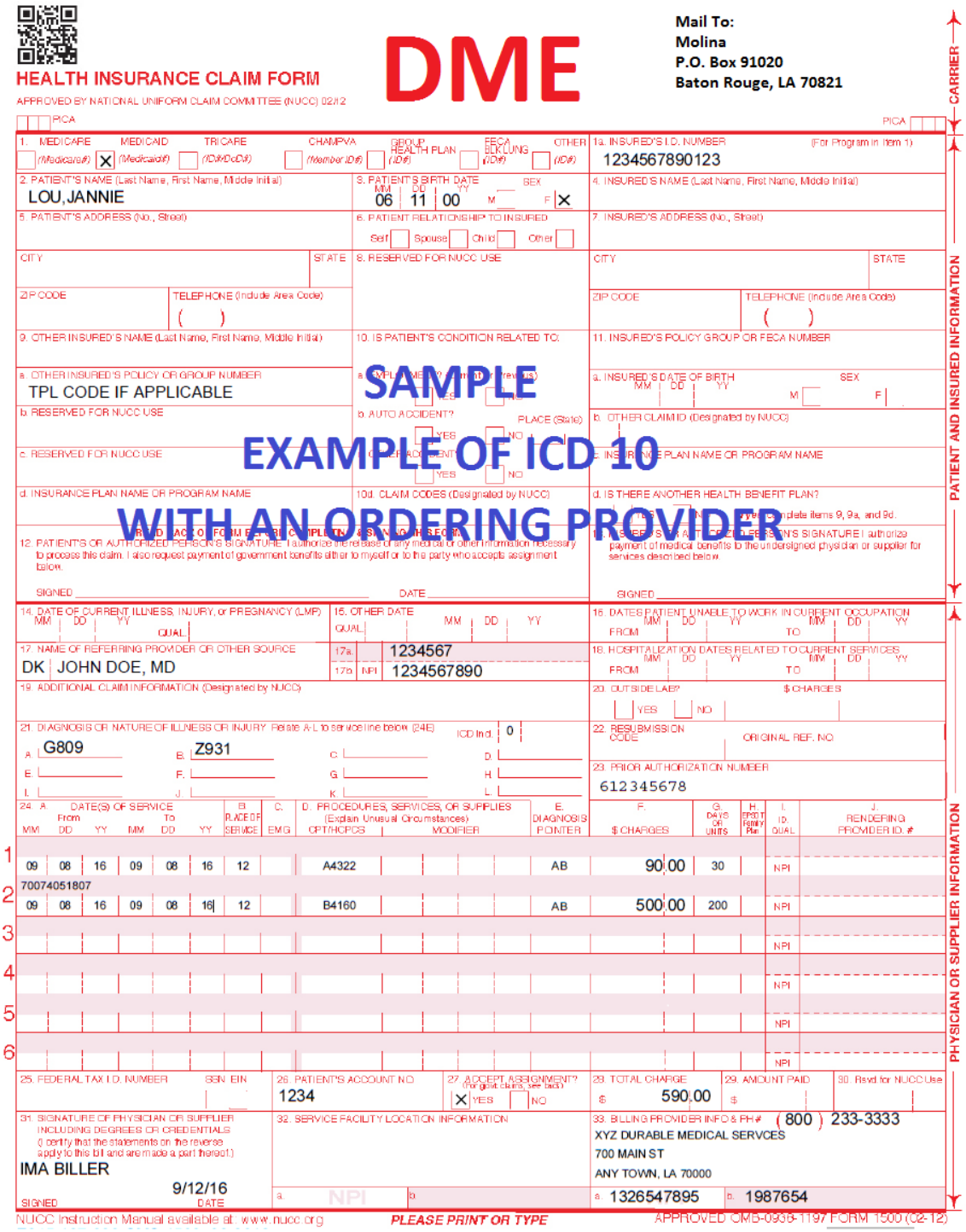
Field/Item #	Description	Instructions	Alerts
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	**Situational** – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). When a modifier(s) is required, enter the applicable modifier in the appropriate field.	**Where modifiers are required, the modifier(s) on the claim must match the modifier(s) on the Prior Authorization.**
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT / Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qualifier	**Optional.** If possible, leave blank	

Field/Item #	Description	Instructions	Alerts
		for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	**Leave Blank.**	
25	Federal Tax I.D. Number	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare payments in this field.**	
30	Reserved for NUCC use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional.** – The practitioner or the practitioner's authorized representative's original signature is no longer required. Enter the date of form completion.	
32	Service Facility	**Situational** – Complete as	

Field/Item #	Description	Instructions	Alerts
	Location Information	appropriate or leave blank.	
32a	NPI#	**Optional.**	
32b	Other ID#	**Situational –** Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI#	**Required** – Enter the billing provider's 10-digit NPI number.	**The 10-digit NPI Number must appear on paper claims.**
33b	Other ID#	**Required** – Enter the billing provider's 7-digit Medicaid ID number. **ID Qualifier – Optional** – If possible, leave blank for Louisiana Medicaid claims.	**The 7-digit Medicaid Provider Number must appear on paper claims.**

A sample form follows.

SAMPLE DME CLAIM FORM
WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/1/15)



HEALTH INSURANCE CLAIM FORM

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

DME

Mail To:
Molina
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

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

3. PATIENT'S BIRTH DATE: 06 11 00 SEX: M F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

SAMPLE
EXAMPLE OF ICD 10
WITH AN ORDERING PROVIDER

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 _____

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

SIGNED _____

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JOHN DOE, MD

17a. 1234567

17b. NPI 1234567890

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. G809 B. Z931 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 612345678

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	09 08 16	09 08 16	12		A4322		AB	90.00	30		NPI	
2	70074051807 09 08 16	09 08 16	12		B4160		AB	500.00	200		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 590.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
IMA BILLER
SIGNED 9/12/16 DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

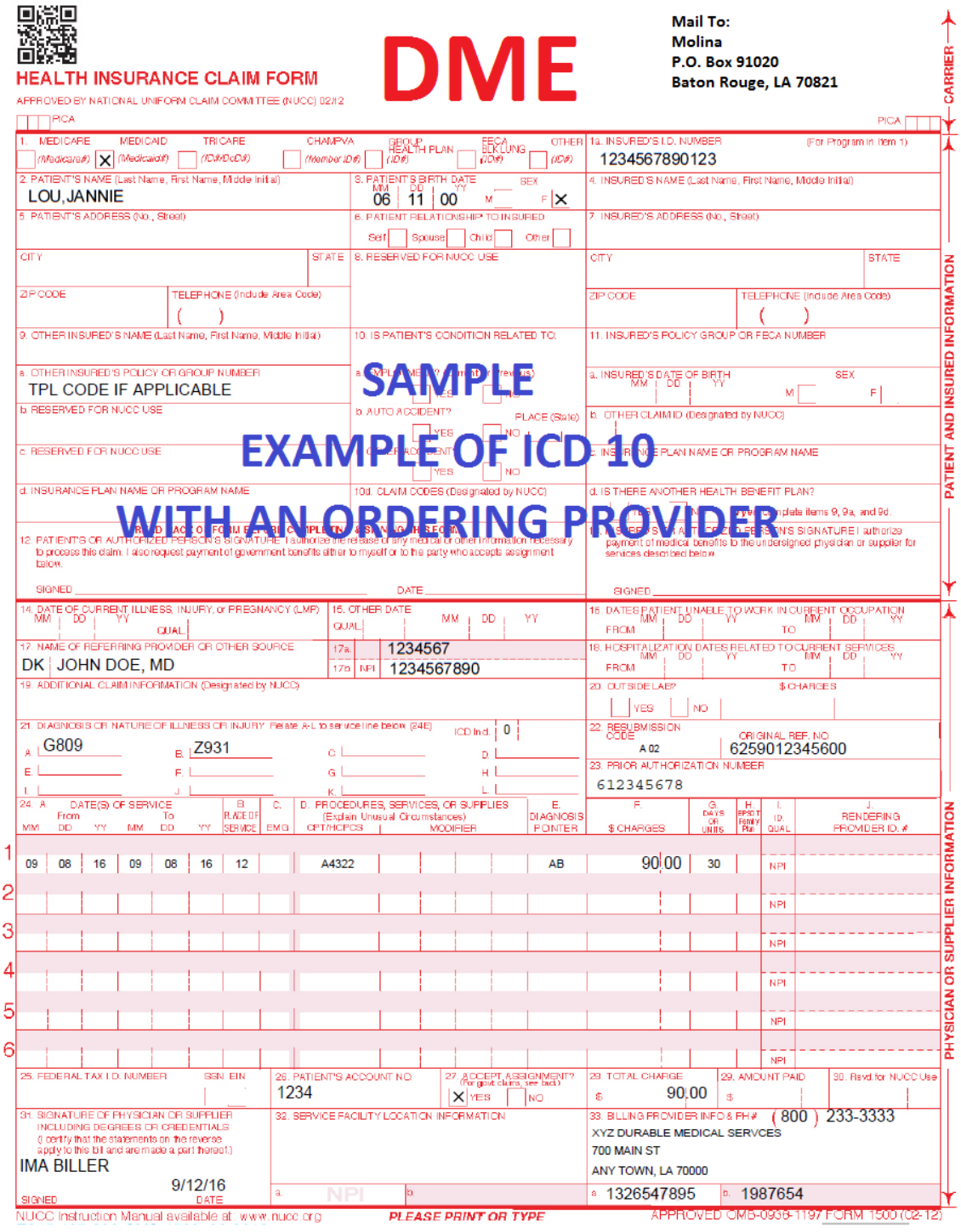
33. BILLING PROVIDER INFO & PH# (800) 233-3333
XYZ DURABLE MEDICAL SERVCES
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE DME CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)



HEALTH INSURANCE CLAIM FORM

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

DME

Mail To:
Molina
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

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

3. PATIENT'S BIRTH DATE: 06 11 00 SEX: M F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JOHN DOE, MD

17a. 1234567

17b. NPI 1234567890

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. G809 B. Z931 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 6259012345600

23. PRIOR AUTHORIZATION NUMBER: 612345678

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	09	08	16	09	08	16	12		A4322		AB	90 00	30		NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 90.00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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

IMA BILLER

SIGNED 9/12/16 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (800) 233-3333

XYZ DURABLE MEDICAL SERVCES
700 MAIN ST
ANY TOWN, LA 70000

a. 1326547895 b. 1987654

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

SAMPLE

EXAMPLE OF ICD 10

WITH AN ORDERING PROVIDER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.