CMS-1500 (02/12) BILLING INSTRUCTIONS FOR APPLIED BEHAVIORAL ANALYSIS

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
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.	

Locator #	Description	Instructions	Alerts
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	Patient Status	Optional.	
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 coverage, the state assigned 6-digit TPL carrier code is required in this field. 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 in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	Other Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	Situational – Complete if appropriate or 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	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	

Locator #	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	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabeled	Situational – Enter if applicable of leave blank.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	
20	Outside Lab?	Optional.	

Locator #	Description	Instructions	Alerts
21	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	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.
		current ICD diagnosis code. NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted	
		to Medicaid.	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	Medicaid Resubmission Code	Situational. If filing an adjustment or void, enter a "7" for an adjustment or an "8" 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	Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).
		from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction	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.

Locator #	Description	Instructions	Alerts
		03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other	
		Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	
23	Prior Authorization Number	Required. All services billed must be Prior Authorized, and the PA number is required to be entered in this field.	
24	Supplemental Information	Situational – Complete if appropriate or leave blank.	
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).	
		Procedure Codes: H2019: Therapeutic Behavioral Service Up to 24 units per day (6 hours); 3- 5 days per week (1 Unit = 15 minutes) No Modifier for BCBA Modifier HM = Para-Professional	

Locator #	Description	Instructions	Alerts
		G9012: Other Specified Case Management Service NOS Up to 4 units per week (1 unit = 15 Minutes) H0032: Mental Health Services Plan Development by Non-Physician — Initial Evaluation Up to 4 hours allowed for the session/visit. Once every 180 days. (1 unit = 1 hour)	
24E	Diagnosis Pointer	Required – Indicates 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	Refer to 24D.
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional.	

Locator #	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is required.	
		Entering the Rendering Provider's NPI in the non-shaded portion of the block is Required if the Providers Medicaid ID number is entered above.	
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 payer. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been	

Locator #	Description	Instructions	Alerts
		made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional - The original signature of the provider is no longer required.	
	Date	Enter the date of form completion.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional	
32b	Unlabeled	Optional	
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.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit LA Medicaid provider number must be entered here.

SAMPLE APPLIED BEHAVIORAL ANALYSIS CLAIM FORM FOR GROUP BILLING WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

HEALTH INSURANCE CLAIM FORM		CARRIER
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA TTT
MEDICARE MEDICAID TRICARE CHAMPVA	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member it	D#) (ID#) (ID#) (ID#)	9876543210123
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
JAYCO, TRAVIS	07 31 2001 M X F	
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 (Indude Area Code)
()		()
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 SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	ZIP CODE TELEPHONE (Indude Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DO YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	SAMPLE	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING	& SIGNING THIS FORM.	YES NO If yes, complete items 9, 9a and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either t below. 	release of any medical or other information necessary o myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0 MM DD YY QUAL. QUAL	THER DATE MM DD YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY FROM TO MY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	NPI	FROM TO 20. OUTSIDE LAB? \$ CHARGES
		YES NO
	vice line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.
A. 30000 B. C. L	D. <u> </u>	
E F G	н	23. PRIOR AUTHORIZATION NUMBER
I J K	L.	456789123
	DURES, SERVICES, OR SUPPLIES ain Unusual Circumstances) CS MODIFIER DIAGNOSIS POINTER	F. G. H. L. J. 20 Ays Part ID. RENDERING CR. Schart ID. PROVIDER ID. #
03 27 14 03 27 14 11 H003	2	1234567 180 00 1 NPI 1234567891
1000		1234567
03 28 14 03 28 14 11 H2019	Α .	180 00 12 NPI 1234567891
		1234567
04 01 14 04 01 14 11 G901:	2 A	
04 04 14 04 04 14 11 H2019	9 A	120 00 8 NPI 1234567891
		NPI S
		J
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	CCOUNT NO. 27. ACCEPT ASSIGNMENT? (For go vt. claims, see back) YES NO	28. TOTAL CHARGE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FA	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (800) 233-3333
INCLUDING DEGREES OR CREDENTIALS	S.E LOOKING THE GRAPHION	(555)255
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		ABC BEHAVIORAL ANALYSIS 500 ALBERT RD SMILEY, LA 70528
Jane Doe 4/0/44		
SIGNED Jane Doe DATE 4/9/14 a.	DI EASE DRINT OR TYPE	a. 1987456123 b. 2123456

SAMPLE APPLIED BEHAVIORAL ANALYSIS CLAIM FORM FOR INDIVIDUAL BILLING WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA T
MEDICARE MEDICAID TRICARE CHAMPVA	A GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member II	ID#) (ID#) (ID#) (ID#)	9876543210123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
JAYCO, TRAVIS	07 31 2001 M X F	T INCUPEDIO ADDEFEC OLS CASSAS
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 (Indude 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)	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	YES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	COTHER ACCIDENT PLE	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
EXA	MPIFOFIC	YES NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize the to process this claim. Lalso request payment of government benefits either to	SIGNING THIS FORM. release of any medical or other information necessary to myself or to the party who accepts assignment	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED	DATE	SIGNED
MM DD YY QUAL QU	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO TO YY
17. NAME OF RÉFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	. NPI	FROM TO 20. OUTSIDE LAB? \$ CHARGES
16. ADDITIONAL ODNIM IN ONIMATION (Designated by NOGO)		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	ervice line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.
A. [30000 B C	D.	A 02 4087156789100
E F G	н ј	23. PRIOR AUTHORIZATION NUMBER
I J K	L. L	456789123
	EDURES, SERVICES, OR SUPPLIES plain Unusual Circumstances) PCS MODIFIER DIAGNOSIS POINTER	F. G. H. I. J. DAYS PSOT ID. RENDERING OR Family QUAL. PROVIDER ID. #
03 28 14 03 28 14 11 H201	9 A	150 00 10 NPI
		NPI
		NPI NPI
		NPI
		NPI
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	(For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FA	YES NO ACILITY LOCATION INFORMATION	\$ 150 00 \$ \$ \$ 33. BILLING PROVIDER INFO & PH# (800) 233-3333
3.3. SIGNITUTE OF PIT SIGNING SUPPLIER INCLUDING DEGREES OR OREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	ACILITY DOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (800) 233-3333 JOHN DOE, ABA 500 ALBERT RD SMILEY, LA 70528
SIGNED John Doe, ABA DATE 4/9/14 a.	b.	a. 1234567891 b. 1234567
Order DATE WALL I		

SAMPLE APPLIED BEHAVIORAL ANALYSIS CLAIM FORM FOR GROUP BILLING WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

160 160 160 160 160 160 160 160 160 160		
EALTH INSURANCE CLAIM FORM		
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA TTT
. MEDICARE MEDICAID TRICARE CHAMPA	A GROUP FECA OTHER	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) ★ (Medicaid #) (ID#/DoD#) (Member	HEALTH PLAN BLK LUNG	1234567890123
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ADALAM, MARY	06 11 00 M FX	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
OTY STATE	8. RESERVED FOR NUCC USE	CITY
ZP CODE TELEPHONE (Indude Area Code)	1	ZIP CODE TELEPHONE (Include Area Code)
2. 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
,		
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
TPL Code if applicable RESERVED FOR NUCCUSE	YES NO	M F
. HESELVES FOLKHOOD SEE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE		G. INSURANCE PLAN NAME OR PROGRAM NAME
I. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
EVA	ADLE OF L	1 N If yes, complete items 9, 9a and 9d.
READ BACK OF FORM # 200 Co. N. Co. N. 20 PATIENTS OR AUTHORIZED PERSONS SIGNATURE. I authorize to be process this claim. I also request payment of government benefits either below.	a vig in a THIS EOF 6 release of any medical or other information necessary to myself or to the party who accepts assignment	DE UP O ZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
MM DD YY QUAL QL	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO TO YY
7. NAME OF RÉFERRING PROVIDER OR OTHER SOURCE 178	L NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO
	ervice line below (24E) ICD Ind. 0	YES NO 22. RESUBMISSION CODE ORIGINAL REF. NO.
_{А. [} F4 19 в. [С. [D	
E F G. [н	23. PRIOR AUTHORIZATION NUMBER
From To PLACEOF (Ex	EDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. G. H. I. J. J. OAYS 19"30T ID. RENDERING OAL. PROVIDER ID. #
MM DD YY MM DD YY SERMOE EMG CPT/HC	PCS MODIFIER POINTER	S CHARGES UNITS Flui QUAL PROVIDER ID. # 1234567
10 08 15 10 08 15 11 H003	32 A	180 00 1 NPI 1234567891 1234567
10 09 15 10 09 15 11 H20	19 A	180 00 12 NPI 1234567891
10 12 15 10 12 15 11 G90	12 A	1234567 72 00 4 NPI 1234567891
		1234567
10 12 15 10 12 15 11 H20	19 HM A	80 00 4 NPI 1234567891
		NPI
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. datms, see back)	NPI
1234	X YES NO	s 512 00 s s 512 00
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.)	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (800) 233-3333 ABC BEHAVIORAL ANALYSIS 500 ALBERT RD SMILEY, LA 70528
GIGNED Ima Biller DATE 10/15/15 a.	b.	a. 1987456123 b. 2123456
UCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

SAMPLE APPLIED BEHAVIORAL ANALYSIS CLAIM FORM FOR INDIVIDUAL BILLING WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

3.23 2 10点回		
EALTH INSURANCE CLAIM FORM		
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA
1. MEDICARE MEDICAID TRICARE CHAMPVI (Medicare #) ★ (Medicaid #) (ID#/DoD#) (Member I	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1) 1234567890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ADALAM, MARY	3. PATIENTS BIRTH DATE SEX MM DD YY 06 11 00 M F X	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)
STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	CITY
TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Include Area Code)
OTHER INSUREDS NAME (Last Name, First Name, Middle initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
PL Code if applicable	YES NO	M F
	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	c. CON A COL E TO YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d is there another health benefit plan?
PATIENTS OR AUTHORIZED PERSONS SIGNATURE—I authorize the to process this claim. I also request payment of government benefits either below.	I N IG THIS DRN Telease of any medican or differ information necessary to myself or to the party who accepts assignment	(NSL 187 S OR A THE B ED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
L DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO DD YY TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 71b.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
	rvice line below (24E) ICD Ind. 0	YES NO 22. RESUBMISSION ORIGINAL REF. NO.
A_[F4 19 B C. [E.]	D. [23. PRIOR AUTHORIZATION NUMBER
I. L J. K. L 4. A. DATE(S) OF SERVICE B. C. D.PROCE	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
	olain Unusual Circumstances) DIAGNOSIS	F. G. H. J. J. OAVS effect ID. RENDERING OR Plan Plan QUAL. PROVIDER ID. #
10 08 15 10 08 15 11 H003	2 A	180 00 1 NPI
0 09 15 10 09 15 11 H201	9 A	180 00 12 NPI
0 12 15 10 12 15 11 G901	2 A	72 00 4 NPI
0 12 15 10 12 15 11 H201	9 HM A	80 00 4 NPI
		NPI
<u> </u>		
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENTS.	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. dalms, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (carify that the statements on the reverse apply to this bill and are made a part thereof.)	X YES NO	\$ 512 00 \$ \$ 512 00 33. BILLING PROVIDER INFO 8 PH# (800) 233-3333 JOHN DOE, ABA 500 ALBERT RD SMILEY, LA 70528
SIGNED Ima Biller DATE 10/20/15 a.	b.	a. 1234567891 b. 1234567
UCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02-1)

SAMPLE APPLIED BEHAVIORAL ANALYSIS CLAIM FORM BILLED AS AN ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

可以			
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			
PICA			PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA GRO	UP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Progra	m in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member ID#) (ID#)	(ID#) (ID#)	9876543210123	
MM	SBIRTH DATE SEX DD YY 31 2001 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
-	31 2001 M X F	7. INSURED'S ADDRESS (No., Street)	
Self	Spouse Child Other		
CITY STATE 8. RESERVI	ED FOR NUCC USE	СПҮ	STATE
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area	Code)
()		()	,
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	IENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOY	MENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	F
b. RESERVED FOR NUCC USE b. AUTO A(YES NO CCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	r
C	ΔΑΛΡΙΕ		
c. RESERVED FOR NUCC USE	CCIDENTY	c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESE	YES NO	A 10 THERE ANOTHER HEALTH DESIGNATION	
G. INSURANCE PLAN NAME OR PROGRAM NAME EXAM.	DIFOFIC	LISTHERE ANOTHER HEALTH BENEFIT PLAN? YES NO If ves. complete items 9. 9a ar	wi Gri
READ BACK OF FORM BEFORE COMPLETING & SIGNING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of ar	THIS FORM.	13. INSURED S OR AUTHORIZED PERSON'S SIGNATURE I	authorize
 PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. Fauthorize the release of an to process this claim. I also request payment of government benefits either to myself or to below. 		payment of medical benefits to the undersigned physician of services described below.	or supplier for
	ATE	SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0THER DATE	. MM . DD . YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCC	CUPATION
MM DD YY QUAL. QUAL	MM DD YY	FROM DD YY TO MM DD	YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SEI	RVICES
71b. NPI		FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line bel	ow (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.	
A. [30000 B. [C. [D	A 02 4087156789100	
E F G	н	23. PRIOR AUTHORIZATION NUMBER	
I. J. K. L 24. A. DATE(S) OF SERVICE B. C. D.PROCEDURES, SEI	L. L. RVICES, OR SUPPLIES E.	456789123 F. G. H. I.	J.
From To PLACE OF (Explain Unusual MM DD YY MM DD YY SBRVICE EMG CPT/HCPCS		DAYS EPSOT ID. REN	IDERING IDER ID. #
	mountait Tontial		
03 28 14 03 28 14 11 H2019	A	150 00 10 NPI	
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		NPI NPI	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
		NPI NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT N	(For govt. claims, see back)		LANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOC	YES NO ATION INFORMATION	\$ 150 00 \$ \$ 33. BILLING PROVIDER INFO & PH# (800) 233-3	222
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I confl) that the statements on the reverse apply to this bill and are made a part thereof.)		JOHN DOE, ABA	1000
		500 ALBERT RD	
		SMILEY, LA 70528	
SIGNED John Doe, ABA DATE 4/9/14 a.	b.	a 1234567891 b 1234567	

SAMPLE APPLIED BEHAVIORAL ANALYSIS CLAIM FORM **BILLED AS AN ADJUSTMENT** WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

EALTH INSURANCE CLAIM FORM		
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA T
. MEDICARE MEDICAID TRICARE CHAMPV	A GROUP FECA OTHER	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DcD#) (Member II	HEALTH PLAN BLK LUNG	1234567890123
. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ADALAM, MARY	06 11 00 M FX	
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
ITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
P CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Include Area Code) ()
OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
RESERVED FOR NUCCUSE	YES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	SAMPLE	c. INSURANCE PLAN NAME OR PROGRAM NAME
. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE	d. ISTHERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BE ORE A 1P	MPLF OF	VO Tyes, complete litems 9, 9a and 9d.
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE II authorize the to process this claim. I also request payment of government benefits either below. 	ralease of any medical or other information necessary to myself or to the party who accepts assignment	payment of medical beneats to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
MM DD YY QUAL QU	OTHER DATE MM DD YY AL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
71b.	NPI	FROM TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	rvice line below (24E) ICD Ind. 0	YES NO 22. RESUBMISSION ORIGINAL REF. NO.
A. F4 19 B. C.	D. I	A 02 5299198798700
E.I F.I G.I	н	23. PRIOR AUTHORIZATION NUMBER
ı J. L. K.	L.	
	DURES, SERVICES, OR SUPPLIES Islain Unusual Circumstances) CS MODIFIER E. DIAGNOSIS POINTER	F. G. H. I. J. DAYS B*BOT ID. RENDERING \$ CHARGES UNITS First QUAL. PROVIDER ID. #
10 08 15 10 08 15 11 H003	2 A	180¦00 1 NPI
		NPI NPI
		NPI NPI
		NPI NPI
		. NPI
<u> </u>		
5. FEDERAL TAX L.D. NUMBER SSN EIN 26. PATIENTS A	ACCOUNT NO. 27 ACCEPT ASSIGNMENTS	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. datms, see back) X YES NO	s 512 00 s s 512 00
	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (800) 233-3333 JOHN DOE, ABA 500 ALBERT RD SMILEY, LA 70528
Ima Pillor		
IGNED Ima Biller DATE 122815 a.	b.	a. 1234567891 b. 1234567

SAMPLE BLANK CMS1500 FORM

1902年 同204年			
HEALTH INSURANCE CLAIM FORM			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			
1. MEDICARE MEDICAID TRICARE CHAMPY.	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in liem 1)	
(Member E	OR) (IDN) (IDN)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)	
8. 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)	a. INSURED'S DATE OF BIRTH SEX	
STREET STORES OF SERVICES STREET HOMBEN	YES NO	a. INSURED'S DATE OF BIRTH DD YY	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENTY PLACE (State) YES NO	b. OTHER CLAIM ID (Designated by NUCC)	
g. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	© INSURANCE PLAN NAME OF PROGRAM NAME	
	YES NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, complete items 9, 9s, and 9d.	
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the	A SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for	
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the to process this claim. I also request payment of government benefits either below. 	to myself or to the party who accepts assignment	services described below.	
SIGNED	DATE	\$IGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. 0	OTHER DATE MAN DO YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17g.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		FROM TO 20. OUTSIDE LAB? \$ CHARGES	
10. ADDITIONAL COMMITTER (LOSSYMER BY THOOL)		YEB NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to servi	ce line below (24E) ICD Ind.	22. RESUBMISSION ORIGINAL REF. NO.	
B. C. L.	D. L.	23. PRIOR AUTHORIZATION NUMBER	
I. J. L. K.	L L		
	DURES, SERVICES, OR SUPPLIES In Unusual Circumstances) CS MODIFIER POINTER	F. G. H. I. DAYS BEST ID. RENDERING SCHARGES UNITS IP PROVIDER ID. #	
		NPI	
		NPI	
		NPI NPI	
		NPI	
		NPI	
		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	g-or gove claims, see back	28. TOTAL CHARGE 29. AMOUNT PAID 30. Ravel for NUCC Use	
31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32, SERVICE FA	YES NO	\$ \$ 33. BILLING PROVIDER INFO & PH # (
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		A STATE OF THE PARTY OF THE PAR	
apply to this bill and are made a part thereof.)			
SIGNED DATE 8.	b.	a NPI b	
NII IOO leete eijee Meenel eneijelde et moore ee	DI EACE DEINE OR TYPE	ADDDOVED OMB 0000 1107 FORM 1500 (00 10)	