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CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

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## APPENDIX C: CLAIMS FILING

PAGE(S) 16

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**CLAIMS FILING**

Hard copy billing of applied behavior analysis (ABA) services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

**Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

**Situational** information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

**Molina Medicaid Solutions  
P.O. Box 91020  
Baton Rouge, LA 70821**

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at [www.lamedicaid.com](http://www.lamedicaid.com), directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

## CMS 1500 (02/12) Billing Instructions for Applied Behavior Analysis

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	<b>Required</b> – Enter the recipient's 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS.  <b>NOTE:</b> The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date  Sex	<b>Situational</b> – Enter the recipient's date of birth using six 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	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<b>Situational</b> – If recipient has no other coverage, leave blank.  If there is other coverage, the state assigned 6-digit TPL carrier code is <b>required</b> 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.	<b>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</b>

**CHAPTER 4: APPLIED BEHAVIOR ANALYSIS****APPENDIX C: CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
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.	
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	OTHER DATE	Leave Blank.	
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 or leave blank.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

Locator #	Description	Instructions	Alerts
21	<p>ICD Indicator</p> <p>Diagnosis or Nature of Illness or Injury</p>	<p><b>Required</b> -- 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.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p><b>Required</b> – Enter the most current ICD diagnosis code.</p> <p>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.</p>	<p>The most specific diagnosis code must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>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 (<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>).</p>
22	Resubmission Code	<p><b>Situational</b> – 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.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.</p> <p>Appropriate reason codes follow:</p> <p>Adjustments</p> <p>01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p>Voids</p> <p>10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>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).</p> <p>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.</p>

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

Locator #	Description	Instructions	Alerts
23	Prior Authorization (PA) Number	<b>Required</b> – All services billed must be prior authorized. The prior authorization number must be entered in this field.	
24	Supplemental Information	<b>Situational</b> – Complete if appropriate or leave blank.	
24A	Date(s) of Service	<b>Required</b> -- 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	<b>Required</b> -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	<b>Situational</b> – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	<b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s). <b>Procedure Codes:</b> <b>H2019:</b> Therapeutic Behavior Service Up to 24 units per day (6 hours); 3- 5 days per week (1 Unit = 15 minutes) <b>No Modifier for BCBA</b> <b>Modifier HM = Para-Professional</b> <b>G9012:</b> Other Specified Case Management Service NOS A maximum of 4 units per week (1 unit = 15 Minutes) <b>H0032:</b> Mental Health Services Plan Development by Non-Physician – Initial Evaluation 1 hour allowed for the session/visit. Once every 180 days. (1 unit = 1 hour)	
24E	Diagnosis Pointer	<b>Required</b> – 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	Amount Charged	<b>Required</b> -- Enter usual and customary charges for the service rendered.	

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

Locator #	Description	Instructions	Alerts
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D	Refer to 24D
24H	EPSDT Family Plan	<b>Situational</b> – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	<b>Optional.</b>	
24J	Rendering Provider ID#	<b>Situational</b> – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is <b>required</b> .  Entering the Rendering Provider's NPI in the non-shaded portion of the block is <b>required</b> if the Provider's Medicaid ID number is entered above.	
25	Federal Tax I.D. Number	<b>Optional.</b>	
26	Patient's Account No.	<b>Situational</b> – 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?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	<b>Situational</b> – 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, <b>leave blank</b> .	
30	Balance Due	<b>Situational</b> – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Optional</b> -- The original signature of the provider is no longer required.  Enter the date of the signature.	

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

Locator #	Description	Instructions	Alerts
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	
32a	NPI	<b>Optional.</b>	
32b	Unlabeled	<b>Optional.</b>	
33	Billing Provider Info & Phone #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	<b>Required</b> – Enter the billing provider's 10-digit NPI number.	
33b	Unlabeled	<b>Required</b> – Enter the billing provider's 7-digit Medicaid ID number.	<b>The 7-digit LA Medicaid provider number must be entered here.</b>

**ISSUED: 09/28/15**  
**REPLACED: 10/21/14**

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

**PAGE(S) 16**

**ABA – Example 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							
1. MEDICARE (Medicare #) <input checked="" 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#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9876543210123</b>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>JAYCO, TRAVIS</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>07 31 2001</b>				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)  CITY  STATE						6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other				7. INSURED'S ADDRESS (No., Street)  CITY  STATE							
ZIP CODE		TELEPHONE (Include Area Code) ( )				8. RESERVED FOR NUCC USE				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? (Place (State)) YES NO				b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? (Place (State)) YES NO				c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10a. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO <i>If yes, complete items 9, 9a and 9d.</i>							
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 MM DD YY QUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				20. OUTSIDE LAB? \$ CHARGES YES NO							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind <b>9</b> A. <b>30000</b> B. C. D. E. F. G. H. I. J. K. L.				22. RESUBMISSION CODE <b>A 02</b> ORIGINAL REF. NO. <b>4087156789100</b>							
24. A. DATE(S) OF SERVICE From To 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. ICD ID. I. RENDERING PROVIDER ID. #						23. PRIOR AUTHORIZATION NUMBER <b>456789123</b>											
1 03 28 14 03 28 14 11 H2019 A 150.00 10 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 gov. claims, see back) YES NO		28. TOTAL CHARGE \$ 150.00		29. AMOUNT PAID \$		30. BALANCE DUE \$			
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 John Doe, ABA DATE 4/9/14						32. SERVICE FACILITY LOCATION INFORMATION  a. b.						33. BILLING PROVIDER INFO & PH # (800) 233-3333  JOHN DOE, ABA 500 ALBERT RD SMILEY, LA 70528  a. 1234567891 b. 1234567					

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## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

ABA – Example Claim Form for Group Billing with ICD-9 Diagnosis Code  
(Dates BEFORE 10/1/15)

## HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE #) <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#) <input type="checkbox"/>		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	
JAYCO, TRAVIS		07 31 2001 M X F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
CITY		Self Spouse Child Other	
STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE		CITY	
TELEPHONE (Include Area Code)		STATE	
( )		ZIP CODE	
( )		TELEPHONE (Include Area Code)	
( )		( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		YES NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		YES NO	
10a. RESERVED FOR LOCAL USE		c. OTHER ACCIDENT? YES NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
a. INSURED'S DATE OF BIRTH MM DD YY SEX		YES NO If yes, complete items 9, 9a and 9d.	
b. OTHER CLAIM ID (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
c. INSURANCE PLAN NAME OR PROGRAM NAME		SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		DATE	
15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		FROM MM DD YY TO MM DD YY	
17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-9		20. OUTSIDE LAB? YES NO \$ CHARGES	
A. 30000 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. SPOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1 03 27 14 03 27 14 11 H0032 A 180 00 1 NPI 1234567		456789123	
2 03 28 14 03 28 14 11 H2019 A 180 00 12 NPI 1234567			
3 04 01 14 04 01 14 11 G9012 A 72 00 4 NPI 1234567			
4 04 04 14 04 04 14 11 H2019 A 120 00 8 NPI 1234567			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For 904, 905, 906, 907) YES NO		28. TOTAL CHARGE \$ 552 00	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED Jane Doe DATE 4/9/14		33. BILLING PROVIDER INFO & PH # (800) 233-3333	
		ABC BEHAVIORAL ANALYSIS	
		500 ALBERT RD	
		SMILEY, LA 70528	
		a. 1987456123 b. 2123456	

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## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

**ABA – Example Claim Form for Individual Billing 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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRECARE (ID#)	CHAMPVA (Member ID#)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>ADALAM, MARY</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>06 11 00</b>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>1234567890123</b>
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? (State) YES NO c. OTHER ACCIDENT? (State) YES NO		11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM DD YY b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO	
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			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? YES NO \$ CHARGES		21. RE-SUBMISSION CODE ORIGINAL REF. NO.	
22. PRIOR AUTHORIZATION NUMBER		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. ICD-10 CODE I. ID. QUAL. J. RENDERING PROVIDER ID #		25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claim, see back) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$	
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 <b>Ima Biller</b> DATE <b>10/20/15</b>		32. SERVICE FACILITY LOCATION INFORMATION <b>JOHN DOE, ABA</b> <b>500 ALBERT RD</b> <b>SMILEY, LA 70528</b>	
33. BILLING PROVIDER INFO & PH# <b>(800) 233-3333</b>		34. BILLING PROVIDER INFO & PH# <b>(800) 233-3333</b>	

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## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

**ABA – Example Claim Form for Group Billing 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											
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S ADDRESS (No., Street)		6. INSURED'S CITY	
ADALAM, MARY		06   11   00 M F <input checked="" type="checkbox"/>		1234567890123							
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)		8. INSURED'S CITY		9. INSURED'S STATE		10. INSURED'S ZIP CODE	
CITY		Self Spouse Child Other		CITY		STATE		ZIP CODE		TELEPHONE (include Area Code)	
STATE		9. RESERVED FOR NUCC USE		CITY		STATE		ZIP CODE		TELEPHONE (include Area Code)	
ZIP CODE		10. IS PATIENT'S CONDITION RELATED TO:		CITY		STATE		ZIP CODE		TELEPHONE (include Area Code)	
TELEPHONE (include Area Code)		a. EMPLOYMENT? (Current or Previous)		CITY		STATE		ZIP CODE		TELEPHONE (include Area Code)	
( )		YES NO		CITY		STATE		ZIP CODE		TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. AUTO ACCIDENT?		11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH		13. INSURED'S SEX		14. INSURED'S PLACE (State)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		PLACE (State)		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		b. OTHER CLAIM ID (Designated by NUCC)	
TPL Code if applicable		c. AUTO ACCIDENT?		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		c. INSURANCE PLAN NAME OR PROGRAM NAME	
b. RESERVED FOR NUCC USE		YES NO		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
c. RESERVED FOR NUCC USE		YES NO		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		If yes, complete items 9, 9a and 9d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		15. INSURED'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.)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		10d. RESERVED FOR LOCAL USE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		SIGNED	
SIGNED		10d. RESERVED FOR LOCAL USE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		DATE	
DATE		10d. RESERVED FOR LOCAL USE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		FROM MM   DD   YY TO MM   DD   YY	
MM   DD   YY		MM   DD   YY		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
QUAL		QUAL		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		FROM MM   DD   YY TO MM   DD   YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		18. OUTSIDE LAB? \$ CHARGES	
17b. NPI		17c. NPI		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		YES NO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		21. RESUBMISSION CODE	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 Ind. 0		22. RESUBMISSION CODE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		23. PRIOR AUTHORIZATION NUMBER	
A. F41.9 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. A. DATE(S) OF SERVICE	
24. A. DATE(S) OF SERVICE		24. B. PLACE OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. C. DATE(S) OF SERVICE	
MM   DD   YY		24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. E. DATE(S) OF SERVICE	
24. E. DATE(S) OF SERVICE		24. F. DIAGNOSIS POINTER		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. F. DIAGNOSIS POINTER	
MM   DD   YY		24. G. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. G. DAYS OF SERVICE	
24. F. DIAGNOSIS POINTER		24. H. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. H. DAYS OF SERVICE	
24. G. DAYS OF SERVICE		24. I. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. I. DAYS OF SERVICE	
24. H. DAYS OF SERVICE		24. J. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. J. DAYS OF SERVICE	
24. I. DAYS OF SERVICE		24. K. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. K. DAYS OF SERVICE	
24. J. DAYS OF SERVICE		24. L. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. L. DAYS OF SERVICE	
24. K. DAYS OF SERVICE		24. M. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. M. DAYS OF SERVICE	
24. L. DAYS OF SERVICE		24. N. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. N. DAYS OF SERVICE	
24. M. DAYS OF SERVICE		24. O. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. O. DAYS OF SERVICE	
24. N. DAYS OF SERVICE		24. P. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. P. DAYS OF SERVICE	
24. O. DAYS OF SERVICE		24. Q. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. Q. DAYS OF SERVICE	
24. P. DAYS OF SERVICE		24. R. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. R. DAYS OF SERVICE	
24. Q. DAYS OF SERVICE		24. S. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. S. DAYS OF SERVICE	
24. R. DAYS OF SERVICE		24. T. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. T. DAYS OF SERVICE	
24. S. DAYS OF SERVICE		24. U. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. U. DAYS OF SERVICE	
24. T. DAYS OF SERVICE		24. V. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. V. DAYS OF SERVICE	
24. U. DAYS OF SERVICE		24. W. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. W. DAYS OF SERVICE	
24. V. DAYS OF SERVICE		24. X. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. X. DAYS OF SERVICE	
24. W. DAYS OF SERVICE		24. Y. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. Y. DAYS OF SERVICE	
24. X. DAYS OF SERVICE		24. Z. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. Z. DAYS OF SERVICE	
24. Y. DAYS OF SERVICE		24. AA. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AA. DAYS OF SERVICE	
24. Z. DAYS OF SERVICE		24. AB. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AB. DAYS OF SERVICE	
24. AA. DAYS OF SERVICE		24. AC. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AC. DAYS OF SERVICE	
24. AB. DAYS OF SERVICE		24. AD. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AD. DAYS OF SERVICE	
24. AC. DAYS OF SERVICE		24. AE. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AE. DAYS OF SERVICE	
24. AD. DAYS OF SERVICE		24. AF. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AF. DAYS OF SERVICE	
24. AE. DAYS OF SERVICE		24. AG. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AG. DAYS OF SERVICE	
24. AF. DAYS OF SERVICE		24. AH. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AH. DAYS OF SERVICE	
24. AG. DAYS OF SERVICE		24. AI. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AI. DAYS OF SERVICE	
24. AH. DAYS OF SERVICE		24. AJ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AJ. DAYS OF SERVICE	
24. AI. DAYS OF SERVICE		24. AK. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AK. DAYS OF SERVICE	
24. AJ. DAYS OF SERVICE		24. AL. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AL. DAYS OF SERVICE	
24. AK. DAYS OF SERVICE		24. AM. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AM. DAYS OF SERVICE	
24. AL. DAYS OF SERVICE		24. AN. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AN. DAYS OF SERVICE	
24. AM. DAYS OF SERVICE		24. AO. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AO. DAYS OF SERVICE	
24. AN. DAYS OF SERVICE		24. AP. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AP. DAYS OF SERVICE	
24. AO. DAYS OF SERVICE		24. AQ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AQ. DAYS OF SERVICE	
24. AP. DAYS OF SERVICE		24. AR. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AR. DAYS OF SERVICE	
24. AQ. DAYS OF SERVICE		24. AS. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AS. DAYS OF SERVICE	
24. AR. DAYS OF SERVICE		24. AT. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AT. DAYS OF SERVICE	
24. AS. DAYS OF SERVICE		24. AU. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AU. DAYS OF SERVICE	
24. AT. DAYS OF SERVICE		24. AV. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AV. DAYS OF SERVICE	
24. AU. DAYS OF SERVICE		24. AW. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AW. DAYS OF SERVICE	
24. AV. DAYS OF SERVICE		24. AX. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AX. DAYS OF SERVICE	
24. AW. DAYS OF SERVICE		24. AY. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AY. DAYS OF SERVICE	
24. AX. DAYS OF SERVICE		24. AZ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. AZ. DAYS OF SERVICE	
24. AY. DAYS OF SERVICE		24. BA. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BA. DAYS OF SERVICE	
24. AZ. DAYS OF SERVICE		24. BB. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BB. DAYS OF SERVICE	
24. BA. DAYS OF SERVICE		24. BC. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BC. DAYS OF SERVICE	
24. BB. DAYS OF SERVICE		24. BD. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BD. DAYS OF SERVICE	
24. BC. DAYS OF SERVICE		24. BE. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BE. DAYS OF SERVICE	
24. BD. DAYS OF SERVICE		24. BF. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BF. DAYS OF SERVICE	
24. BE. DAYS OF SERVICE		24. BG. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BG. DAYS OF SERVICE	
24. BF. DAYS OF SERVICE		24. BH. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BH. DAYS OF SERVICE	
24. BG. DAYS OF SERVICE		24. BI. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BI. DAYS OF SERVICE	
24. BH. DAYS OF SERVICE		24. BJ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BJ. DAYS OF SERVICE	
24. BI. DAYS OF SERVICE		24. BK. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BK. DAYS OF SERVICE	
24. BJ. DAYS OF SERVICE		24. BL. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BL. DAYS OF SERVICE	
24. BK. DAYS OF SERVICE		24. BM. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BM. DAYS OF SERVICE	
24. BL. DAYS OF SERVICE		24. BN. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BN. DAYS OF SERVICE	
24. BM. DAYS OF SERVICE		24. BO. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BO. DAYS OF SERVICE	
24. BN. DAYS OF SERVICE		24. BP. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BP. DAYS OF SERVICE	
24. BO. DAYS OF SERVICE		24. BQ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BQ. DAYS OF SERVICE	
24. BP. DAYS OF SERVICE		24. BR. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BR. DAYS OF SERVICE	
24. BQ. DAYS OF SERVICE		24. BS. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BS. DAYS OF SERVICE	
24. BR. DAYS OF SERVICE		24. BT. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BT. DAYS OF SERVICE	
24. BS. DAYS OF SERVICE		24. BU. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BU. DAYS OF SERVICE	
24. BT. DAYS OF SERVICE		24. BV. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BV. DAYS OF SERVICE	
24. BU. DAYS OF SERVICE		24. BW. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BW. DAYS OF SERVICE	
24. BV. DAYS OF SERVICE		24. BX. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BX. DAYS OF SERVICE	
24. BW. DAYS OF SERVICE		24. BY. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BY. DAYS OF SERVICE	
24. BX. DAYS OF SERVICE		24. BZ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. BZ. DAYS OF SERVICE	
24. BY. DAYS OF SERVICE		24. CA. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CA. DAYS OF SERVICE	
24. BZ. DAYS OF SERVICE		24. CB. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CB. DAYS OF SERVICE	
24. CA. DAYS OF SERVICE		24. CC. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CC. DAYS OF SERVICE	
24. CB. DAYS OF SERVICE		24. CD. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CD. DAYS OF SERVICE	
24. CC. DAYS OF SERVICE		24. CE. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CE. DAYS OF SERVICE	
24. CD. DAYS OF SERVICE		24. CF. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CF. DAYS OF SERVICE	
24. CE. DAYS OF SERVICE		24. CG. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CG. DAYS OF SERVICE	
24. CF. DAYS OF SERVICE		24. CH. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CH. DAYS OF SERVICE	
24. CG. DAYS OF SERVICE		24. CI. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CI. DAYS OF SERVICE	
24. CH. DAYS OF SERVICE		24. CJ. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CJ. DAYS OF SERVICE	
24. CI. DAYS OF SERVICE		24. CK. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CK. DAYS OF SERVICE	
24. CJ. DAYS OF SERVICE		24. CL. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CL. DAYS OF SERVICE	
24. CK. DAYS OF SERVICE		24. CM. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CM. DAYS OF SERVICE	
24. CL. DAYS OF SERVICE		24. CN. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CN. DAYS OF SERVICE	
24. CM. DAYS OF SERVICE		24. CO. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CO. DAYS OF SERVICE	
24. CN. DAYS OF SERVICE		24. CP. DAYS OF SERVICE		a. INSURED'S DATE OF BIRTH		MM   DD   YY		M F		24. CP. DAYS OF SERVICE	
24. CO. DAYS OF SERVICE		24.									

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CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

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## APPENDIX C: CLAIMS FILING

PAGE(S) 16

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**Adjustments and Voids**

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.**

**Adjustments/Voids Appearing on the Remittance Advice**

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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**CHAPTER 4: APPLIED BEHAVIOR ANALYSIS**

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**APPENDIX C: CLAIMS FILING**

**PAGE(S) 16**

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When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

**Sample forms are on the following pages.**

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

Sample CMS-1500 Form Billed as an Adjustment 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

1. MEDICARE (Medicare #) <input checked="" 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#) <input type="checkbox"/>		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 X F	
JAYCO, TRAVIS		07 31 2001 M X F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code)		ZIP CODE	
( )		( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? (State) YES NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED DATE		SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. 30000 B. C. D. E. F. G. H. I. J. K. L.		A 02 4087156789100	
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. ICD-9 (From Plan) I. ID. QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1 03 28 14 03 28 14 11 H2019 A 150 00 10 NPI		456789123	
2			
3			
4			
5			
6			
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 \$ 150 00	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED John Doe, ABA DATE 4/9/14		33. BILLING PROVIDER INFO & PH# (800) 233-3333	
a. 1234567891		b. 1234567	

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**ISSUED: 09/28/15**  
**REPLACED: 10/21/14**

## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

**PAGE(S) 16**

**Sample CMS-1500 Form Billed as an 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

PICA

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1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (IDM/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)
<input checked="" type="checkbox"/> X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1234567890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>ADALAM, MARY</b>			3. PATIENT'S BIRTH DATE MM DD YY <b>06   11   00</b>			SEX M F X <b>F</b>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( ) ( )			6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other			7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( ) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? c. OTHER ACCIDENT?			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME	
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>TPL Code if applicable</b> b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? e. YES NO f. IF YES, complete items 9, 9e 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							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 FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 71a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS or NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24c) ICD Ind. 0						22. RESUBMISSION CODE ORIGINAL REF. NO. <b>A 02 5299198798700</b>	
A. F4 19 B. C. D. E. F. G. H. I. J. K. L.						23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. SPOT /Perk Fee I. ID. QUAL J. RENDERING PROVIDER ID.#							
10   08   15   10   08   15   11			H0032			180   00   1   NPI	
						NPI	
						NPI	
						NPI	
						NPI	
						NPI	
						NPI	
						NPI	
						NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. <b>1234</b>			27. ACCEPT ASSIGNMENT? X YES NO	
						28. TOTAL CHARGE \$ <b>512   00</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>512   00</b>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH# (800) 233-3333 <b>JOHN DOE, ABA 500 ALBERT RD SMILEY, LA 70528</b>	
SIGNED <b>Ima Biller</b> DATE <b>122815</b>			a. b.			a. <b>1234567891</b> b. <b>1234567</b>	

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## CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

## APPENDIX C: CLAIMS FILING

PAGE(S) 16

## Sample CMS-1500 Form



## HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										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 <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY										CITY																																																	
STATE										STATE																																																	
ZIP CODE										ZIP CODE																																																	
TELEPHONE (Include Area 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. EMPLOYMENT? (Current or Previous)										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. OTHER CLAIM ID (Designated by NUCC)																																							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) ( )										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																							
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.										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 FROM MM DD YY TO MM DD YY																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										23. PRIOR AUTHORIZATION NUMBER																																																	
A. _____ B. _____ C. _____ D. _____										F. \$ CHARGES										G. DAYS OR UNITS										H. EMPLOYER/Party Plan										I. ID. QUAL										J. RENDERING PROVIDER ID. #									
E. _____ F. _____ G. _____ H. _____																																																											
I. _____ J. _____ K. _____ L. _____																																																											
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																																																											
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25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> (For gov. claims, see back)										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Reserved 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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ( )																																							
SIGNED DATE										a. NPI b. NPI										a. NPI b. NPI																																							

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