# CLAIMS RELATED INFORMATION

Hard copy billing of waiver 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 be processed. 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:

Gainwell P.O. Box 91020
Baton Rouge, LA 70821

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid website at 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.

## CMS 1500 (02/12) INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

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

| Locator # | 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 "WAIVER" at the top center of the Louisiana Medicaid claim form.** |
| 1a | Insured's ID Number | **Required** – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.<br><br>**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<br><br>Sex | **Situational** – 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).<br><br>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 Insured | **Situational** – Complete if appropriate or leave blank. | |
| 7 | Insured's Address | **Situational** – Complete if appropriate or leave blank. | |
| 8 | RESERVED FOR NUCC USE | **Leave Blank** | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| **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.<br><br>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.<br><br>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** | 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: | **Leave Blank.** | |
| **11** | Insured's Policy Group or FECA Number | **Situational** – Complete if appropriate or leave blank. | |
| **11a** | Insured's Date of Birth<br><br>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** | Insured's or Authorized Person's Signature (Payment) | **Situational** – Obtain signature if appropriate or leave blank. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| **14** | Date of Current Illness / Injury / Pregnancy | **Leave Blank.** | |
| **15** | OTHER DATE | **Leave Blank.** | |
| **16** | Dates Patient Unable to Work in Current Occupation | **Leave Blank.** | |
| **17** | Name of Referring Provider or Other Source | **Leave Blank.** | |
| **17a** | Other ID# | **Leave Blank.** | |
| **17b** | NPI | **Situational** – If 17 or 17a is completed, this field is required. | |
| **18** | Hospitalization Dates Related to Current Services | **Leave Blank.** | |
| **19** | ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | **Leave Blank.** | |
| **20** | Outside Lab? $Charges | **Leave Blank.** | |
| **21** | ICD Indicator<br><br>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.<br><br>0 ICD-10-CM<br><br>**Required** – Enter the ICD 10 diagnosis code **Z76.89**.<br><br>**NOTE**: The ICD-10-CM "external cause of injury diagnosis codes V, W, X, and Y will be accepted as non-primary diagnosis codes. | **Diagnosis Code Z76.89 may be used on all ADHC claims.** |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| **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.<br><br>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.<br><br>Appropriate reason codes follow:<br><br><u>Adjustments</u><br>01 = Third Party Liability Recovery<br>02 = Provider Correction<br>03 = Fiscal Agent Error<br>90 = State Office Use Only – Recovery<br>99 = Other<br><br><u>Voids</u><br>10 = Claim Paid for Wrong Recipient<br>11 = Claim Paid for Wrong Provider<br>00 = Other | **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.** |
| **23** | Prior Authorization (PA) Number | **Required** – Enter the 9-Digit PA number 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. Bill one date of service per claim line.<br><br>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.<br><br>**A separate claim must be billed for each month if the recipient's dates of service cross the end of a calendar month.** | **Note: Claims must be split billed at the end of each month.** |
| **24B** | Place of Service | **Required** -- Enter the appropriate place of service code for the services rendered.<br><br>**99 Other** | |
| **24C** | EMG | **Leave Blank.** | |

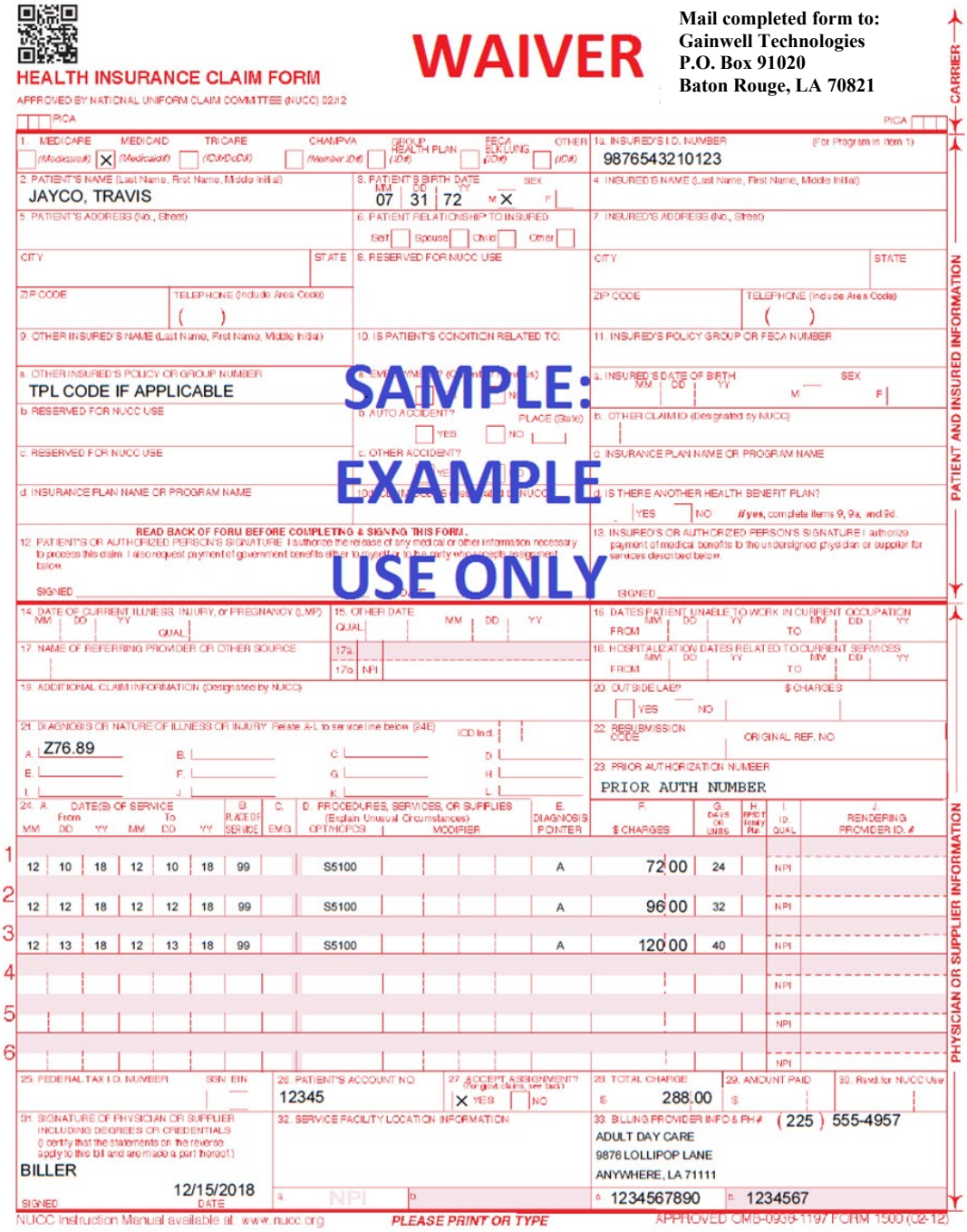
| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| **24D** | Procedures, Services, or Supplies | **Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s).<br><br>**S5100 – ADHC Services** | |
| **24E** | Diagnosis Pointer | **Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. | |
| **24F** | $ Charge | **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<br><br>**NOTE: ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) per week.** | **Reminder: 1 Unit is equal to 15 minutes of service** |
| **24H** | EPSDT Family Plan | **Leave Blank.** | |
| **24I** | ID Qualifier | **Optional.** If possible, leave blank for Louisiana Medicaid billing. | |
| **24J** | Rendering Provider ID # | **Leave Blank.** | |
| **25** | Federal Tax ID 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. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| **29** | Amount Paid | **Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.<br><br>If TPL does not apply to the claim, leave blank. | . |
| **30** | Reserved for NUCC use | **Leave Blank.** | |
| **31** | Signature of Physician or Supplier Including Degrees or Credentials<br><br>Date | **Optional** -- The practitioner or the practitioner's authorized representative's original signature is no longer required.<br><br>**Required** -- Enter the date of the signature. | |
| **32** | Service Facility Location Information | **Situational** – Complete as appropriate or leave blank. | |
| **32a** | NPI# | **Optional.** | |
| **32b** | Other ID# | **Optional.** | |
| **33** | Billing Provider Info & Phone # | **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 must appear on paper claims.** |
| **33b** | Other ID# | **Required** – Enter the billing provider's 7-digit Medicaid ID number.<br><br>**ID Qualifier - Optional.** If possible, leave blank for Louisiana Medicaid billing. | **The 7-digit Medicaid Provider Number must appear on paper claims.** |

## REMINDER: MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

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

## SAMPLE ADHC CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

PICA

1. MEDICARE (Medicare#) X | 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): 9876543210123

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 72 SEX M X 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: 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? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES

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

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

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 Z76.89 B C D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: PRIOR AUTH 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 | 12 10 18 | | 12 10 18 | | | 99 | | S5100 | | A | 72 00 | 24 | | NPI | |
| 2 | 12 12 18 | | 12 12 18 | | | 99 | | S5100 | | A | 96 00 | 32 | | NPI | |
| 3 | 12 13 18 | | 12 13 18 | | | 99 | | S5100 | | A | 120 00 | 40 | | NPI | |
| 4 | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 12345

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

28. TOTAL CHARGE $ 288 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.)

BILLER

SIGNED 12/15/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( 225 ) 555-4957

ADULT DAY CARE
9876 LOLLIPOP LANE
ANYWHERE, LA 71111

a. 1234567890 b. 1234567

SAMPLE: EXAMPLE USE ONLY

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

## ADJUSTING/VOIDING CLAIMS

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.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

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.

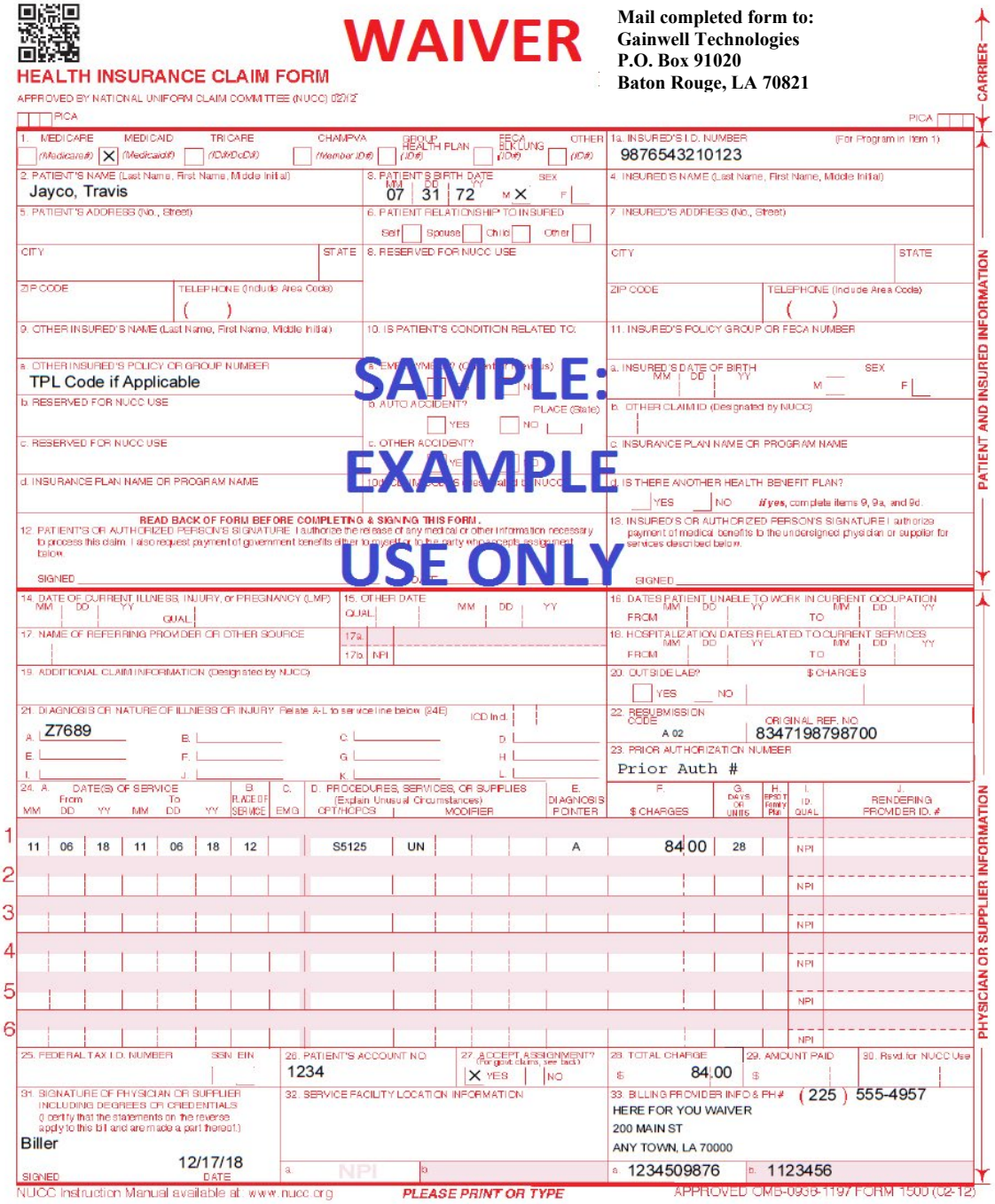
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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.**

## SAMPLE WAIVER CLAIM FORM ADJUSTMENT



WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) X | 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): 9876543210123

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

3. PATIENT'S BIRTH DATE: 07 31 72 SEX: M X 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) ( )

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? 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 _____

SAMPLE: EXAMPLE USE ONLY

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

17a.

17b. NPI

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.

A. Z7689 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 8347198798700

23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

| 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 | 11 | 06 | 18 | 11 | 06 | 18 | 12 | | S5125 | UN | | A | 84 00 | 28 | | 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: $ 84.00

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.)

Biller

SIGNED 12/17/18 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( 225 ) 555-4957

HERE FOR YOU WAIVER
200 MAIN ST
ANY TOWN, LA 70000

a. 1234509876 b. 1123456

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

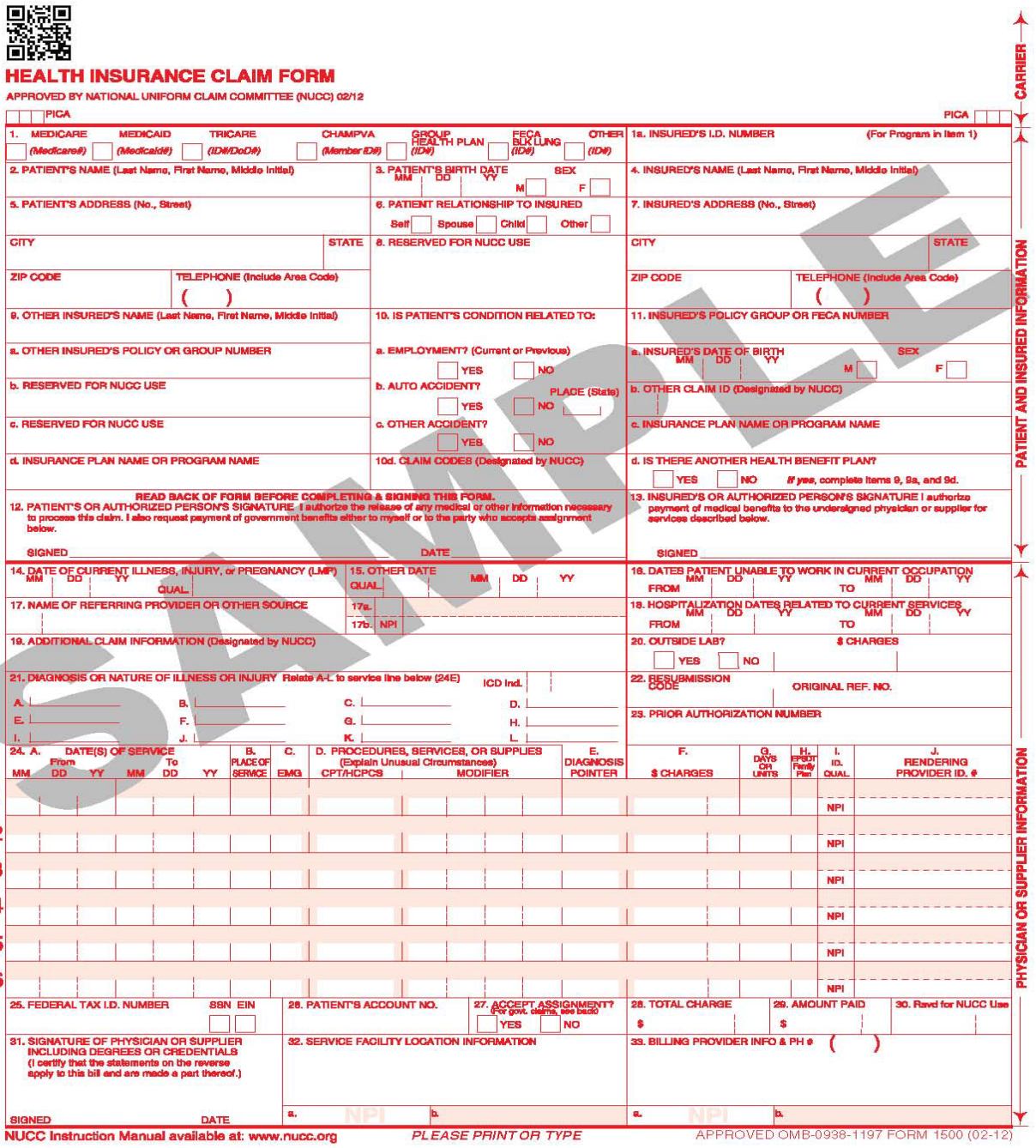
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

## SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website below for general information concerning topics relative to general claims filing.

http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf