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CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

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## APPENDIX E – CLAIMS FILING

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**CLAIMS FILING**

Hard copy billing of waiver services are 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 website 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.

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CMS-1500 (02/12) INSTRUCTIONS FOR  
ADULT DAY HEALTH CARE (ADHC) SERVICES  
EFFECTIVE WITH DATE OF SERVICE 4/1/16

You must write “WAIVER” at the top center of the claim form!

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 #).	You must write “WAIVER” at the top center of the Louisiana Medicaid claim form.
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 must 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.	Formerly UB-04 Locator 60.
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	Formerly UB-04 Locator 8 & 58.
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.	Formerly UB-04 Locator 10 & 11.
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.	Formerly UB-04 Locator 9.
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	Leave Blank.	
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p><b>Situational</b> – If recipient has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	<p>Formerly UB-04 Locator 61.</p> <p><b>ONLY</b> the 6-digit code should be entered in this field. <b>DO NOT</b> enter dashes, hyphens, or the word TPL in the field.</p>
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Leave Blank.	
11	Insured's Policy Group or FECA Number	<b>Situational</b> – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	<b>Situational</b> – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Leave Blank	
15	OTHER DATE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
16	Dates Patient Unable to Work in Current Occupation	Leave Blank	
17	Name of Referring Provider or Other Source	Leave Blank	
17a	Unlabeled	Leave Blank	
17b	NPI	Leave Blank	
18	Hospitalization Dates Related to Current Services	Leave Blank	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank	
20	Outside Lab?	Leave Blank	
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>0 ICD-10-CM</p> <p><b>Required</b> – Enter the ICD 10 diagnosis code <b>Z76.89</b>.</p> <p><b>NOTE:</b> The ICD-10-CM "V", "W", "X", and "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>Formerly UB-04 Locator 66.</p> <p>Formerly UB-04 Locator 67.</p> <p>Diagnosis Code Z76.89 may be used on all ADHC claims.</p>

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Locator #	Description	Instructions	Alerts
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><u>Adjustments</u>  01 = Third Party Liability Recovery  02 = Provider Correction  03 = Fiscal Agent Error  90 = State Office Use Only – Recovery  99 = Other</p> <p><u>Voids</u>  10 = Claim Paid for Wrong Recipient  11 = Claim Paid for Wrong Provider  00 = Other</p>	<p>Formerly UB-04 Locator 64.</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>
23	Prior Authorization (PA) Number	<b>Required</b> – Enter the 9-Digit PA number in this field.	Formerly UB-04 Locator 63.
24	Supplemental Information	<b>Situational</b>	
24A	Date(s) of Service	<p><b>Required</b> -- Enter the date of service for each procedure. Bill one date of service per claim line.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p> <p><b>A separate claim must be billed for each month if the recipient's dates of service cross the end of a calendar month.</b></p>	<p>Formerly UB-04 Locator 45.</p> <p>Note: Claims must be split billed at the end of each month.</p>
24B	Place of Service	<p><b>Required</b> -- Enter the appropriate place of service code for the services rendered.</p> <p>99 Other</p>	
24C	EMG	Leave Blank.	

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Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	<b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s).  S5100 – ADHC Services	Formerly UB-04 Locator 44.
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.	
24F	Amount Charged (\$ Charge)	<b>Required</b> -- Enter usual and customary charges for the service rendered.	Formerly UB-04 Locator 47.
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D  <b>NOTE:</b> ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) per week.	Formerly UB-04 Locator 46.  Reminder: 1 Unit is equal to 15 minutes of service
24H	EPSDT Family Plan	Leave Blank	
24I	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank	
25	Federal Tax I.D. Number	<b>Optional.</b>	Formerly UB-04 Locator 5.
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.	Formerly UB-04 Locator 3A.
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.	Formerly UB-04 Locator 47.

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Locator #	Description	Instructions	Alerts
29	Amount Paid	<b>Situational</b> – 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.  If TPL does not apply to the claim, leave blank.	Formerly UB-04 Locator 54.
30	Reserved for NUCC use	<b>Leave Blank.</b>	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Optional</b> -- The practitioner or the practitioner's authorized representative's original signature is no longer required.  <b>Required</b> -- Enter the date of the signature.	
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.	Formerly UB-04 Locator 1.
33a	NPI	<b>Required</b> – Enter the billing provider's 10-digit NPI number.	Formerly UB-04 Locator 56.  The 10-digit NPI must appear on paper claims.
33b	Unlabeled	<b>Required</b> – Enter the billing provider's 7-digit Medicaid ID number.  ID Qualifier - <b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	Formerly UB-04 Locator 57.  The 7-digit Medicaid Provider Number <u>must</u> 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**

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SAMPLE ADHC CLAIM FORM WITH ICD-10 DIAGNOSIS CODE  
(DATES ON OR AFTER 10/01/15)

## WAIVER

## HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRI-CARE <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) <b>9876543210123</b>																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>JAYCO, TRAVIS</b>												3. PATIENT'S BIRTH DATE MM <b>07</b> DD <b>31</b> YY <b>72</b> SEX <b>M</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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												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) 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												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO												11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> 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 (MM/DD/YY) QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI												15. OTHER DATE (MM/DD/YY) QUAL 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. <b>Z76.89</b> B. C. D. E. F. G. H. I. J. K. L. ICD-10: <b>0</b> 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER <b>987654321</b>																																															
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OF UNITS H. EPSDT (Family Plan) I. ID QUAL J. RENDERING PROVIDER ID, #																																																																							
1 04 01 16 04 01 16 99 S5100 A 72.00 24 NPI																																																																							
2 04 04 16 04 04 16 99 S5100 A 96.00 32 NPI																																																																							
3 04 05 16 04 05 16 99 S5100 A 120.00 40 NPI																																																																							
4																																																																							
5																																																																							
6																																																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For dental claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ <b>288.00</b>												29. AMOUNT PAID \$												30. Rev'd 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.) <b>JOHN DOE 4/6/16</b>												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. <b>1234567890</b> b. <b>1234567</b>																																															

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



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**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.

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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.**

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE  
(DATES ON OR AFTER 10/01/15)

## WAIVER

## HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICAID <input checked="" type="checkbox"/> (Medicaid) <input type="checkbox"/> (Medicare) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (GROUP HEALTH PLAN) <input type="checkbox"/> (ECCA/BLK/LUNG) <input type="checkbox"/> (OTHER)		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 72</b> SEX <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		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 STATE ZIP CODE TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 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		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. OTHER CLAIM ID (Designated by NUCC) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO d. INSURANCE PLAN NAME OR PROGRAM NAME	
11. INSURED'S DATE OF BIRTH MM DD YY SEX <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input type="checkbox"/>		12. INSURED'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 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 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. NPI 17b. 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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to service line below (24E)) A. <b>Z76.89</b> B. C. D. E. F. G. H. I. J. K. L. ICD-10 Ind. <b>0</b>	
22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. <b>6105198765400</b>		23. PRIOR AUTHORIZATION NUMBER <b>987654321</b>	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMQ C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SEN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For group claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <b>96.00</b> 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.) <b>JOHN DOE 5/2/16</b>		32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b. <b>1234567890</b> c. <b>1234567</b>	
33. BILLING PROVIDER INFO & PH# (225) 555-4957 ADULT DAY CARE 9876 LOLLIPOP LANE ANYWHERE, LA 71111		34. BILLING PROVIDER INFO & PH# (225) 555-4957 ADULT DAY CARE 9876 LOLLIPOP LANE ANYWHERE, LA 71111	

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## SAMPLE CLAIM FORM



## HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
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)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
CITY										CITY									
STATE										STATE									
ZIP CODE										ZIP CODE									
TELEPHONE (Include Area Code)										TELEPHONE (Include Area Code)									
8. RESERVED FOR NUCC USE										11. INSURED'S POLICY GROUP OR FECA NUMBER									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
10. IS PATIENT'S CONDITION RELATED TO:										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)									
a. EMPLOYMENT? (Current or Previous)										15. OTHER DATE									
b. AUTO ACCIDENT?										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
c. OTHER ACCIDENT?										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
10d. CLAIM CODES (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
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.										19. OUTSIDE LAB? \$ CHARGES									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										20. YES <input type="checkbox"/> NO <input type="checkbox"/>									
14. DATE										21. RESUBMISSION CODE ORIGINAL REF. NO.									
15. QUAL										22. PRIOR AUTHORIZATION NUMBER									
16. QUAL										23. PRIOR AUTHORIZATION NUMBER									
17. QUAL										24. A. DATE(S) OF SERVICE									
18. QUAL										25. FEDERAL TAX I.D. NUMBER									
19. QUAL										26. PATIENT'S ACCOUNT NO.									
20. QUAL										27. ACCEPT ASSIGNMENT? (For gov. claims, see back)									
21. QUAL										28. TOTAL CHARGE									
22. QUAL										29. AMOUNT PAID									
23. QUAL										30. Reserved for NUCC Use									
24. QUAL										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.)									
25. QUAL										32. SERVICE FACILITY LOCATION INFORMATION									
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