CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING PAGE(S) 12

CLAIMS FILING

Hard copy billing of ambulatory surgical center services are billed on the paper CMS-1500 (02/12) claim form or electronically in the 837P 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:

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

This appendix includes the following:

- 1. Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form; and
- 2. Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

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CHAPTER 29: AMBULATORY SURGICAL CENTERS

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CMS 1500 (02/12) INSTRUCTIONS FOR AMBULATORY SURGICAL CENTERS

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the beneficiary's 13-digit Medicaid I.D. number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS or REVS. NOTE: The beneficiaries' 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 beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the beneficiary'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 beneficiary.	
4	Insured's Name	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the beneficiary'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		

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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 beneficiary has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility Verification System (MEVS) response as the Network Provider Identification Number. Make sure the EOB(s) from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered for commercial and Medicare HMOs in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE
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	Employer's Name or School Name	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness, Give First Date	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Optional.	
17a	Unlabeled	Leave Blank.	
17b	NPI	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Leave Blank.	
20	Outside Lab?	Optional.	

CHAPTER 29: AMBULATORY SURGICAL CENTERS

Locator #	Description	Instructions	Alerts
21	ICD Ind. Diagnosis or Nature of Illness or Injury	Required Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM Required Enter the most current ICD diagnosis code. NOTE: 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.	The most specific diagnosis codes must be used. General codes are not acceptable. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
22	Resubmission Code	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	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). 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.

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CHAPTER 29: AMBULATORY SURGICAL CENTERS

Locator #	Description	Instructions	Alerts
23	Prior Authorization Number	Situational – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is required to be entered.	
24	Supplemental Information	Leave Blank.	
24A	Date(s) of Service	Required Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Required Enter the appropriate place of service code for the services rendered.	
24C	EMG	Situational – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank	
25	Federal Tax I.D. Number	Optional.	

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Locator #	Description	Instructions	Alerts
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. Do not report Medicare payments in this field.	
		Do not report medicare payments in this neid.	
30 Rsvd for NUCC use		Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Enter the date of form completion.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabelled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required - Enter the billing provider's 10 digit NPI number.	
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number must appear on paper claims.

CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING PAGE(S) 12

Example of Billing for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

48/245 回機回		
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02	12	
PICA		PICA
MEDICARE MEDICALD TRICARE CHAN Medicald III (IDM Dodit) Medicard III (IDM Dodit)	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) X (Medicald #) (ID#/DoD#) (Memb 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY	1234567890123 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LOU, JANNIE	06 19 85 M FX	,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
CITY STA	Self Spouse Child Other B. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Include Area Code) ()
9. OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		a INSURED'S DATE OF BIRTH SEX
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 SEX
b. RESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State)	ZIP CODE TELEPHONE (Include Area Code) () 11. INSUREDS POLICY GROUP OR FECA NUMBER a. INSUREDS DATE OF BIRTH M D YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	- SAMP1-F	c. INSURANCE PLAN NAME OR PROGRAM NAME
C. PECENTED FOR HOOD OCE	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE SOM LET	AIVIPLE OF	If yes, complete items 9, 9e and 9d.
 PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize to process this claim. I also request payment of government benefits eit below. 		payment of medical benefits to the undesigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15.OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY
	17a. 71b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILL NESS OR INJURY Relate A-L 1	o service line below (24E) ICD Ind 9	YES NO
	o service line below (24E) ICD ind. 9 D. 78729 D. 53081	22. RESUBMISSION ORIGINAL REF. NO.
E F	3. H.	23. PRIOR AUTHORIZATION NUMBER
I. J. J. P. 24. A. DATE(S) OF SERVICE B. C. D.PR	C. L. L. OCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
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2		NPI NPI
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<i>E</i>		
5		NPI NPI
6		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIEN	T'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. daims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234	YES NO	s 900 00 s s 900 00
31. SIGNATURE OF PHYSIC AN OR SUPPLER INCLUDING DEGREES OR CREDENTIALS () contily that the statements on the reverse apply to this bill and are made a part thereot)	E FACILITY LOCATION INFORMATION	33 BILING PROMOER INFO & PH# (225) 555-4957 SURGI CENTER 123 MAIN ST ANY TOWN, LA 70000
SIGNED IMA BILLER DATE 1/7/15 a.	b.	a. 1234567891 b. 1234567
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CHAPTER 29: AMBULATORY SURGICAL CENTERS

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Example of Billing for Ambulatory Surgical Centers with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

EALTH INSURANCE CLAIM FORM		
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA
MEDICARE MEDICAID TRICARE CHAMPV	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member I	D#) (ID#) (ID#) (ID#)	1234567890123 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PATIENT'S NAME (Last Name, First Name, Middle Initial) OU, JANNIE	MM DD YY 06 19 85 M FX	4. INSUREDS NAME (Last Name, PESt Name, Milode Intral)
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
TY STATE	8. RESERVED FOR NUCC USE	CITY STATE
P CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Include Area Code)
/ \		()
OTHER INSUREDS NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
,		
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
PL Code if applicable	YES NO	M F
RESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
DESCRIPTION FOR ALLOS LIST	SAMDIF	c. INSURANCE PLAN NAME OR PROGRAM NAME
RESERVED FOR NUCC USE	0. (1) 3 MO (1 N	U. INSURANCE PLAN NAME OR PROGRAM NAME
NSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	ADLEGE	
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PATIENT'S OR AUTHORIZED PERSON'S SIGN	re-ass, of any muses, ther in the assument to myself or to the party who accepts assignment	payment of measure be, ents to the undersigned physician or supplier for services described below.
below.		
SIGNED	DATE	SIGNED
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QUAL QU NAME OF REFERRING PROVIDER OR OTHER SOURCE 170		FROM 10
NAME OF RÉFERRING PROVIDER OR OTHER SOURCE 17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	No.	20. OUTSIDE LAB? \$ CHARGES
, , , , , , , , , , , , , , , , , , , ,		VES NO
	arvice line below (24E) ICD Ind. 0	22. RESUBMISSION ORIGINAL REF. NO.
R 1084	R 13 19 D K2 19	
F G	н	23. PRIOR AUTHORIZATION NUMBER
J. K.L. A. DATE(S) OF SERVICE B. C. D.PROCI	L. L. EDURES SERVICES OR SUPPLIES E.	
From To PLACEOF (Exc	plain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. I. DAYS EPSOT ID. RENDERING OR Fently ID. RENDERING OR Fently ID. PROVIDER ID. #
I DD YY MM DD YY SERVICE EMG CPT/HC	PCS MODIFIER POINTER	\$ CHARGES UNITS PRIN QUAL. PROVIDER ID. #
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<u> </u>		
		NPI NPI
		NPI NPI
FEDERAL TAXLD NUMBER SSN EIN 26. PATIENTS	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	
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1234 SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE F.	ACCOUNT NO. 27. ACCEPT. ASSIGNMENT? OF APP. date. see back) YES NO.	NPI 30 BALANCE DUE 5 900 00 5 5 900 00 33 BILING PROVIDER INFO & PH# (225) 555-4957
1234 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS INCLUDING DEGREES OR CREDENTIALS Outfly that be statements on the reverse	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5. 900 00 5. 5. 900 00 33. BILLING PROVIDER INFO & PH# (225) 555-4957 SURGI CENTER
1234 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE F.	YES NO	28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5 900 00 5 5 900 00 33. BILLING PROVIDER INFO & PH# (225) 555-4957 SURGI CENTER 123 MAIN ST
1234 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS INCLUDING THE statements on the inverse	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5. 900 00 5. 5. 900 00 33. BILLING PROVIDER INFO 8. PH# (225) 555-4957 SURGI CENTER

CHAPTER 29: AMBULATORY SURGICAL CENTERS

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Example of Billing Adjustment for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

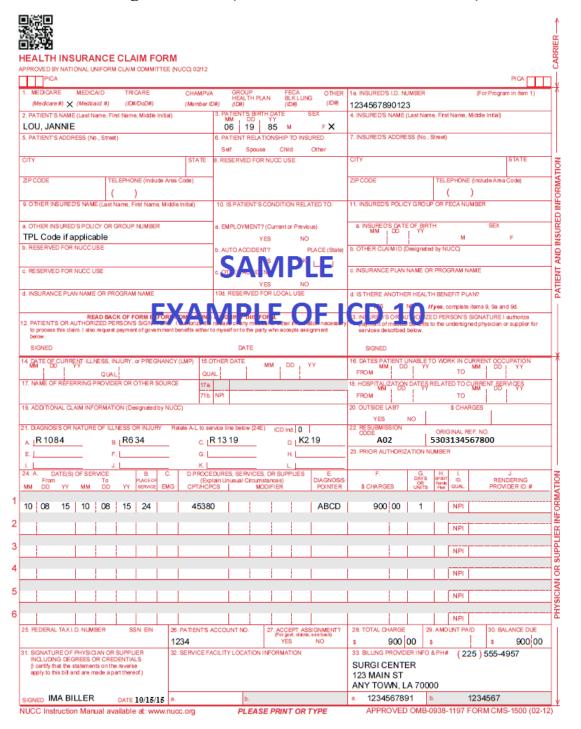
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PICA						PICA
. MEDICARE MEDICA		CHAMPVA	GROUP FECA HEALTH PLAN BLK	A OTHER LUNG (IDIII)	1a. INSURED'S I.D. NUMBER	(For Program in Itam 1)
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OU, JANNIE	ile, Filot Name, Middle illis		MM DD YY 06 19 85 M	FΧ	4. INSUREDS HAME (Last Hai	no, Prochane, miode intaly
PATIENT'S ADDRESS (No.	, Street)		ATIENT RELATIONSHIP TO	INSURED	7. INSURED'S ADDRESS (No.,	, Street)
			elf Spouse Child	Other		
TY		STATE 8. RE	ESERVED FOR NUCC USE		CITY	STATE
PCODE	TELEPHONE (Indude A	rea Code)			ZIP CODE	TELEPHONE (Include Area Code)
	()					()
OTHER INSURED'S NAME	(Last Name, First Name, Mi	ddle Initial) 10.	IS PATIENT'S CONDITION I	RELATED TO:	11. INSURED'S POLICY GROU	IP OR FECA NUMBER
OTHER INSURED'S POUC PL Code if applical		a. 🖯	MPLOYMENT? (Current or P		a. INSURED'S DATE OF BIR	TH SEX
RESERVED FOR NUCCUS		h Al	YES UTO ACCIDENT?	NO PLACE (State)	b. OTHER CLAIM ID (Designate	
		5.7	CARAL			
RESERVED FOR NUCC US	SE .	c. @	T I MOL D N		c. INSURANCE PLAN NAME O	IR PROGRAM NAME
			YES	NO		
NSURANCE PLAN NAME	OR PROGRAM NAME		RESERVED FOR LOCAL U			TH BENEFIT PLAN?
RF/	D BACK OF FORM BEFOR	C M T TIN 4 SI	III FILE	UF		If yes, complete items 9, 9a and 9d. ED PERSON'S SIGNATURE I authorize
PATIENTS OR AUTHORIZ	ED PERSON'S SIGNATUR		se of any medical or other inf elforto the party who accept			to the undersigned physician or supplier for
SIGNED			DATE		SIGNED	
DATE OF CURRENT ILLN	ESS, INJURY, or PREGNAN	CY (LMP) 15.OTHER QUAL.	R DATE MM DD	YY	16. DATES PATIENT UNABLE MM DD YY FROM	TO WORK IN CURRENT OCCUPATION TO DD YY TO Y
NAME OF REFERRING P	ROVIDER OR OTHER SOU	ROE 17a. 71b. NPI		·	18. HOSPITALIZATION DATES MM DD YY FROM	RELATED TO CURRENT SERVICES TO
ADDITIONAL CLAIM INFO		IUCC)			20. OUTSIDE LAB? YES NO	\$ CHARGES
DIAGNOSIS OR NATURE			ine below (24E) ICD Ind.		22. RESUBMISSION CODE	ORIGINAL REF. NO.
78907	B. 78321	_{C. [} 787		53081	A 02 23. PRIOR AUTHORIZATION N	4361134567800
<u> </u>	F.	. G K. I	нլ		23. PRIOR AUTHORIZATION IS	YOMBER
A. DATE(S) OF SERV	ACE B. C	D.PROCEDURE	ES, SERVICES, OR SUPPLI	ES E.	F. G.	H. I. J.
From I DD YY MM	TO PLACE OF SERVICE EM	IG CPT/HCPCS	nusual Circumstances) MODIFIER	DIAGNOSIS POINTER	F. G. DAYS OR \$ CHARGES UNITS	Plan U.A. RENDERING PROVIDER ID. #
15 14 12	15 14 24	45380		ABCD	900 00 1	NPI
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						NPI
1 1	1 1 1		1 1 1		1 1	Lund
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SIGNATURE OF PHYSICI	AN OR SUPPLIER CCREDENTIALS	1234	YES YES	NO	\$ 900 00 33. BILLING PROVIDER INFO SURGI CENTER 123 MAIN ST	9. AMOUNT PAID 30. BALLANCE DUE \$ 900 00 00 00 00 00 00 0
SIGNATURE OF PHYSICI. INCLUDING DEGREES Of	AN OR SUPPLIER CCREDENTIALS	1234	YES YES	NO	\$ 900 00 33. BILLING PROVIDER INFO SURGI CENTER	9. AMOUNT PAID 30. BALLANCE DUE \$ 900 00 00 00 00 00 00 0

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APPENDIX B: CLAIMS FILING

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Example of Billing Adjustment for Ambulatory Surgical Centers with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)



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Example of Blank Form

回信日 第2章 回収・数 HEALTH INSURANCE CLAIM FORM		
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA TITLE
1. MEDICARE MEDICAID TRICARE CHAMPY (Medicare#) (Medicaid#) (IDM/DoD#) (Member II	- HEALTH PLAN - BLK LUNG -	I 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 SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	T INDUIDED ADDRESS (A) Charact
S. PATIENT S ADDRESS (No., Street)	Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
()		()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
The state of the s	YES NO	ZIP CODE TELEPHONE (Include Area Code) (1) 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH DD W M F b. OTHER CLAIM ID (Deelignated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLANY
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENTY PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	YES NO	© INSURANCE PLAN NAME OF PROGRAM NAME
W. I THOMAS IS AD I DOT 1000 CODE	G. OTHER ACCIDENT? YES NO	WINDS STATE FLOW NAME OF FROM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
DEAD DARK OF FORM DEFORE COMM.		YES NO # yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this dailm. I also request payment of government benefits either below.	elease of any medical or other information necessary to myself or to the party who accepts assignment	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.	OTHER DATE NO	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD WY
QUAL	*	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.	. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES WM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?
	to the below the pro-	YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Relate A-L to serv	PALLER STATE OF THE STATE OF TH	22. RESUBMISSION ORIGINAL REF. NO.
B. C. L	D. L	23. PRIOR AUTHORIZATION NUMBER
I. J. K.	L	
	DURES, SERVICES, OR SUPPLIES In Unusual Circumstances) CS MODIFIER DIAGNOSIS POINTER	F. DAYS HE I. D. RENDERING PROVIDER ID. # \$ CHARGES UNITS TO QUAL PROVIDER ID. # NPI NPI NPI NPI NPI
		NPI NPI
		NPI
		NPI NPI
		NPI
		The state of the s
25. FEDERAL TAX I.D. NUMBER S8N EIN 26. PATIENT'S /	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. Ravd for NUCC Use s
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	CILITY LOCATION INFORMATION	39. BILLING PROVIDER INFO & PH # ()
SIGNED DATE 8.	DI FACE DEINT OF TYPE	APPROVED OMP 0000 1107 FORM 1500 (02 12)