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:

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

ISSUED: 09/21/21 REPLACED: 09/22/15

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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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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CHAPTER 29: AMBULATORY SURGICAL CENTERS

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.	
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.

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APPENDIX B: CLAIMS FILING PAGE(S) 12

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

EALTH INSURANCE CLAIM FORM	
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) (
PICA	PICA
	MPVA GROUP FECA OTHER 1a. INSUREDS LD. NUMBER (For Program in Item 1) ### HEALTH PLAN BLK LUNG (IDM)
(Medicare #) ★ (Medicaid #) (ID#/DoD#) (Me PATIENT'S NAME (Last Name, First Name, Middle Initial)	1234567890123 1234567890120 1234567890123 1234567890120 1234567890120 1234567890120 123456789012
OU, JANNIE	06 19 85 M F X
. PATIENT'S ADDRESS (No., Street)	PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)
to a second	Self Spouse Child Other
ITY ST	ATE 8. RESERVED FOR NUCC USE CITY STATE
P CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Include Area Code)
()	()
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: 11. INSUREDS POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a FMPI CYMENT?/Current or Previous). a INSUREDS DATE OF BIRTH SEX
PL Code if applicable	a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX MM DD YY M F
RESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIMID (Designated by NUCC)
	CARADIE
RESERVED FOR NUCC USE	a. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE
EV	AMPIFOFICE Q //yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COM-L	TING & SIGNING THIS FORTE
PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I author to process this claim. I also request payment of government benefits.	ze the release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED	DATE SIGNED
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	
MM DO DO DATE OF THE STATE OF T	15. OTHER DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY MM DD YY NOW DD YY FROM TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
, NAME OF REFERRING PROVIDER OR OTHER SOURCE	17.a 18. HOSPITAL ZATTON DATES RELATED TO CURRENT SERVICES 77.b NPI FROM TO
NAME OF RÉFERRING PROVIDER OR OTHER SOURCE ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	71b NPI FROM TO 20. OUTSIDE LAB? \$ CHARGES
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	71b. NPI FROM TO 20. OUTSIDE LAB? \$ CHARGES YES NO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-	71b NPI
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-	71b NP
ADDITIONAL CLAM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 178907 8 [78321 1 J J	TO TO TO TO TO TO TO TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 78907	T1b NP
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 78907	TO NPI
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1 F. L 1 A DATE(S) OF SERVICE FROM TO PLACE OF PLACE OF MM DD YY MM DD YY SERVICE EMG OF	T1b NP
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1 F. L 1 A DATE(S) OF SERVICE FROM TO PLACE OF PLACE OF MIND DD YY MM DD YY SERVICE EMG OF	TO TO TO TO TO TO TO TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1	TO NPI
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1	TO NPI
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1	TO TO TO TO TO TO TO TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1	TO NPI
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B. 178 32 1 F. L. I. A. DATE(S) OF SERVICE From To PALOE OF PALOE OF MIND DD YY MM DD YY SERVICE EMG OF	TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1 F. L 1 A DATE(S) OF SERVICE FROM TO PLACE OF PLACE OF MIND DD YY MM DD YY SERVICE EMG OF	TID. NPI
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B. 178 32 1 F. L. I. A. DATE(S) OF SERVICE From To PALOE OF PALOE OF MIND DD YY MM DD YY SERVICE EMG OF	TO
ADDITIONAL CLAM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07	TID
ADDITIONAL CLAM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07	TID
ADDITIONAL CLAM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 1789 07 B 178 32 1 F. L 1 A DATE(S) OF SERVICE PACEON EMG CP 10 DD YY MM DD YY GERROOF EMG CP 2 15 14 12 15 14 24 4 FEDERAL TAX LD NUMBER SSN EN 28. PATIE 1234 SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVI	TID
ADDITIONAL CLAM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 178 9 07 B	TID
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A- 78907	TID

CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING

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

79		
ALTH INSURANCE CLAIM FORM		
OVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA TT
EDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	1a. INSURED'S LD. NUMBER (For Program in Item 1)
Medicare ∅) X (Medicaid ∅) (IDØ/DoDØ) (Member	HEALTH PLAN BLK LUNG (IDIII) (IDIII) (IDIII)	1234567890123
TIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
U, JANNIE	06 19 85 M F X	
TIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	I CITY I STATE
, , , , , , , , , , , , , , , , , , ,	o. NEGERVED FOR NOCE OFF	
CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Include Area Code)
()		()
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
L Code if applicable	YES NO	a. INSUREDS DATE OF BIRTH SEX
SERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	CARADIE	
SERVED FOR NUCC USE	- DAIVIP LE	c. INSURANCE PLAN NAME OR PROGRAM NAME
212 MARS DI AN ANAS DE 220 COR MANAS	YES NO	
SURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM B FFOR OM NATIENT'S OR AUTHORIZED PERSONS SIGN	Ve III PHIS FOR A	3. IN JRI /S OR JULIO ZED PERSON'S SIGNATURE I authorize
ATIENT'S OR AUTHORIZED PERSON'S SIGN	re as a any muse ther in asia necessity	y playment of measure boundts to the undersigned physician or supplier for services described below.
low.		(100 CASAC 690 CASAC 640 C
IGNED	DATE	SIGNED
M DO YY	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD YY TO MM DD YY TO MM DD YY
QUAL QU AME OF REFERRING PROVIDER OR OTHER SOURCE 178		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
71b		FROM TO YY
DDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		YES NO
	invice line below (24E) ICD Ind. 0	22. RESUBMISSION ORIGINAL REF. NO.
	R 13 19 LK2 19	23. PRIOR AUTHORIZATION NUMBER
F. L G. L	н	20 PRIOR AUTHORIZATION HOMBER
A. DATE(S) OF SERVICE B. C. D.PROCI	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J. DAYS B*80T ID. RENDERING
From To PUCCOR (Exp DD YY MM DD YY SERVICE EMG CPT/HC	olain Unusual Circumstances) DIAGNOSIS PCS MODIFIER POINTER	\$ CHARGES UNITS Fairly QUAL. PROVIDER ID. #
100 45 40 100 145 104 1 1 1	0	1 000100 1 4 1 1
08 15 10 08 15 24 4538	0 ABCD	900 00 1 NPI
		NPI NPI
		NPI
		NPI NPI
		NPI
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
		NPI
EDERAL TAX I.D. NUMBER SSN EIN 26. PATIENTS	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. dialms, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234	YES NO	s 900 00 s s 900 00
ICLUDING DEGREES OR CREDENTIALS	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (225) 555-4957
certify that the statements on the reverse oply to this bill and are made a part thereof.)		SURGI CENTER 123 MAIN ST
		ANY TOWN, LA 70000
IMA BILLER DATE 10/15/15	b.	a. 1234567891 b. 1234567

CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING

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

EALTH INSURANCE CLAIM FOR	R.A						
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE							
PICA							PICA
MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA OTHER	1a INSURED'S LD. N	JMBER	F	or Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#)	(Member ID)	#) (IDII)	(IDII) (IDII)	123456789012			
PATIENT'S NAME (Last Name, First Name, Middle Initia	1)	3. PATIENT'S BIRTH	DATE SEX	4. INSURED'S NAME		e, First Name, Middle	e Initial)
OU, JANNIE			85 M F X				
PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATION	ONSHIP TO INSURED	7. INSURED'S ADDRE	SS (No., S	(neet)	
		Self Spouse	Child Other				
Y	STATE	B. RESERVED FOR N	NUCC USE	CITY			STATE
CODE TELEPHONE (Indude A	on Cada			ZIP CODE		TELEPHONE (Indi	and a Alman Conday
TELEPHONE (HIDDEN	da Code)			ZIFCODE		()	ade Alea Code)
THE BING HOERS NAME II and Name Sign Name Mil	Adding the Indianal V	40 IC DATICHTIC CO	ONDITION RELATED TO:	11. INSURED'S POLIC	V C DOLLD		
OTHER INSURED'S NAME (Last Name, First Name, Mic	xile initial)	TU IS PATIENT S CO	UNUITION RELATED TO:	11. INSUREDS POLIC	I GROUP	OR FECA NUMBER	N.
OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE	OF BIRTH	н	SEX
PL Code if applicable		a. EMPLOTMENT (MM DD	YY	M	F
ESERVED FOR NUCCUSE		b. AUTO ACCIDENT		b. OTHER CLAIMID (Designated		57
MANAGE COLORES AND COMPANION COMPA		CAR	A Dd. F	, and a second	-		
ESERVED FOR NUCC USE		C OT LAW T N	VIPLE	c. INSURANCE PLAN	NAME OR	PROGRAM NAME	
		VE	s NO				
ISURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FO	R LOCAL USE	d ISTHERE ANOTHE	R HEALTH	BENEFIT PLAN?	
	X V	МИР	FOE		Jr.	yes, complete items	9, 9a and 9d.
READ BACK OF FORM BEFOR	COM LETING	SIGNING THIS FO	LUF	3. Ned Rue S OR A	HORIZE	D PERSON'S SIGN.	ATURE I authorize
PATIENTS OR AUTHORIZED PERSON'S SIGNATURE oprocess this claim. I also request payment of government			or other information necessa who accepts assignment	ry payment of medical services described	benefits to	the undersigned pl	hysician or supplier for
pelow.							
SIGNED		DATE		SIGNED			
DATE OF CURRENT ILLNESS, INJURY, or PREGNAN	CY (LMP) 15.0T	THER DATE M	IM . DD , YY	16. DATES PATIENT U	INABLETO	WORK IN CURRE	INT OCCUPATION
QUAL	QUA	_		FROM	2.7	то	00
NAME OF REFERRING PROVIDER OR OTHER SOUR				100000000000000000000000000000000000000			I
IN THE OF REPERTAINS PROVIDER OR OTHER SOUP	11.50			18. HOSPITALIZATION	DATESR	ELATED TO CURR	ENT SERVICES
HOME OF REPERTING PROVIDER OR OTHER SOUP	11.50	NPI		100000000000000000000000000000000000000	DATESR	ELATED TO CURR TO	ENT SERVICES
	71b.	NPI		18. HOSPITALIZATION	DATESR		
ADDITIONAL CLAIM INFORMATION (Designated by N	71b.			18. HOSPITALIZATION FROM 20. OUTSIDE LAB? YES	DATES R	то	
ADDITIONAL CLAIM INFORMATION (Design atted by N DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	71b. UCC)	vice line below (24E)	Too many or .	18. HOSPITAL IZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE		TO \$ CHARGES ORIGINAL REF. N	0
ADDITIONAL CLAIM INFORMATION (Design atted by N DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	71b. UCC)		ICD Ind. 9 D. [53081	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE A 02	NO	TO \$ CHARGES ORIGINAL REF. N 436113456	0
ADDITIONAL CLAIM INFORMATION (Design atted by N DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	71b. UCC)	vice line below (24E)	Too many or .	18. HOSPITAL IZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE	NO	TO \$ CHARGES ORIGINAL REF. N 436113456	0
ADDITIONAL CLAIM INFORMATION (Designated by N DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 78907	71b. WCC) Relate A-L to sen C. L G. L K.	vice line below (24E)	D 53081	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE A 02	NO ATION NU	TO \$ CHARGES ORIGINAL REF. N 436113456	0
DAGNOSIS OR NATURE OF ILLNESS OR INJURY 178907 B [78321] F:	Relate A-L to sen	vice line below (24E) 8729 DURES, SERVICES, (25) and Unusual Circumster	D. 53081	18. HOSPITALIZATION FROM DO FROM DO 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE A 02 23. PRIOR AUTHORIZ	NO ATION NU	TO \$ CHARGES ORIGINAL REF. N 4361134567 MBER	7800
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CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING PAGE(S) 12

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

(ZR)						
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ROVED BY NATIONAL UNIFORM CLAIM COMMITTE TOPICA	E (NUCC) 02/12					PICA CT
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ATIENT'S ADDRESS (No., Street)			TIONSHIP TO INSURED	7. INSURED'S ADDR	ESS (No., Street)	
		Self Spour	se Child Other			
	STATE	B. RESERVED FOR	R NUCC USE	СПУ		STATE
e Person				A	A	Company of the
CODE TELEPHONE (Include	Area Code)			ZIP CODE	TELEPHONE (Incl	ude Area Code)
()					()	
HER INSURED'S NAME (Last Name, First Name, M	liddle Initial)	10. IS PATIENT'S	CONDITION RELATED TO:	11. INSURED'S POLI	CY GROUP OR FECA NUMBE	R
HER INSURED'S POLICY OR GROUP NUMBER		- FMDI CVANENT	2/0	a INSUDERS DAT	TE OF BIRTH	SEX
Code if applicable			7 (Current or Previous) YES NO	a INSUREDS DAT	I YY	F
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		CAL	No A DALE			
SERVED FOR NUCC USE		O. OID E MO VE	VIPLE	c. INSURANCE PLAN	NAME OR PROGRAM NAME	
			YES NO			
SURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED	FOR LOCAL USE	d. IS THERE ANOTH	ER HEALTH BENEFIT PLAN?	
	VAR	ADI	FOF	ICT 1	N If yes, complete items	9, 9a and 9d.
READ BACK OF FORM F FO	R OW IN	V G IN - HIS F	OF A	3. INI JRF /SOR	U IO ZED PERSON'S SIGN	
process this claim. I also request payment of government	ent banefts either to	myself or to the pa	rty who accepts assignment	services described	 boundits to the undersigned pl d below. 	nysician or supplier for
low.		-				
IGNED				O COLUMN		
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AME OF REFERRING PROVIDER OR OTHER SOL DDITIONAL CLAIM INFORMATION (Designated by I AGNOSIS OR NATURE OF ILLNESS OR INJURY R 1084 B R6 34 F. J DATE(S) OF SERVICE FROM YV MM DD YY SERMOR B DD YY MM DD YY SERMOR B EDERAL TAX LD NUMBER SSN EIN GNATURE OF PHYSICIAN OR SUPPLIER CLUDING DEGREES OR CREDENTIALS GNATURE OF PHYSICIAN OR SUPPLIER CLUDING DEGREES OR CREDENTIALS	QUA ITAL 71b NUCC Relate A-L to sen- C	NPI NOE line below (248 13 19 DURES, SERVICES IN URUSUAL CTOURS M CCOUNT NO.	E) ICD Ind. 0 D K2 19 H L L S. OR SUPPLIES E INSTANCES DIAGNO DIVISION	16. DATES PATIENT FROM D 18. HOSPITALIZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION OODE A02 23. PRIOR AUTHORI DSIS S CHARGES CD 900 00	NO DATES RELATED TO CURRY TO S CHARGES NO ORIGINAL REF. N 53031345678 ZATION NUMBER DATE OF THE PROPERTY OF T	RENDERING PROVIDER ID. #

CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING PAGE(S) 12

Example of Blank Form

EALTH INSURANCE CLAIM FORM			
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			
PICA			PICA
MEDICARE MEDICAID TRICARE CHAMPI	- HEALTH PLAN - BLK LUNG -	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare#) (Medicald#) (ID#/DoD#) (Member			
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)
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
	Self Spouse Child Other		1
Y STATE		CITY	STATE
510000	Part & Protest Name of Calculation and	1 Charles	
CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHON	IE (Include Area Code)
()			
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA N	MBER
	-		
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX F
RESERVED FOR NUCC USE	b. AUTO ACCIDENTY		
enviousma Al Telas Cirit Piteria	YES NO	b. OTHER CLAIM ID (Designated by NUCC)	
ESERVED FOR NUCC USE	G. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM	NAME
	YES NO		
SURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT P	LAN?
		YES NO # yes, comple	ste Items 9, 9a, and 9d.
MEAD BACK OF FORM SEFORE COSIN_EMIN PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the process the claim. I also request payment of government banefits either elbox.	release of any medical or other information necessary r to myself or to the party who accepts seeignment	 INSURED'S OR AUTHORIZED PERSON'S payment of medical benefits to the undersit services described below. 	ned physician or supplier for
BIGNED DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.	OTHER DATE	SIGNED	CLIDDENT OCCUPATION
MM DD YY QUAL QL	JAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN (
NAME OF REFERRING PROVIDER OR OTHER SOURCE 17	8.	18. HOSPITALIZATION DATES RELATED TO	CURRENT SERVICES
17	b. NPI	FROM	
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	HARGES
		YES NO	
DIAGNOSIS OF NATURE OF ILLNESS OF INJURY Relate A-L to ser	vice line below (24E) ICD Ind.	22. RESUBMISSION ORIGINAL F	REF. NO.
B. C. I	D	25. PRIOR AUTHORIZATION NUMBER	100 LITTLE
F. G.	Н	25. PRIOR ACTIONIZATION NUMBER	
A. DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E.	F g H. l.	J.
From To PLACEOF (Expl	lain Unusual Circumstances) DIAGNOSIS PCS MODIFIER POINTER	F. G. H. I. DAYS PROT ID. S CHARGES UNITS Pan QUAL	PROVIDER ID. #
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PEDERAL TAX ID. NUMBER SSN EIN 28. PATIENT'S	ACCOUNT NO. 27. ACCEPT, ASSIGNMENT?	NPI	ND 30. Ravel for NUCC Ur
	ACCOUNT NO. 27. ACCEPT, ASSIGNMENT? YES NO AGILITY LOCATION INFORMATION	NPI NPI NPI	AID 30. Rawd for NUCC Ur
SIGNATURE OF PHYSICIAN OR SUPPLIER NCLUDING DEGREES OR CREDENTIALS 122. SERVICE F. 124. SERVICE F. 125. SERVICE F. 126. SERVICE F. 127. SERVIC	YES NO	NPI NPI NPI NPI NPI SE. TOTAL CHARGE S S	ND 30. Ravel for NUCC Us