
CHAPTER 29: AMBULATORY SURGICAL CENTERS

APPENDIX B: CLAIMS FILING

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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:

Molina Medicaid Solutions
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.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

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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 recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> 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 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). 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		

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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	<p>Situational – 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 required in this block. The carrier code is indicated on the Medicaid Eligibility Verification System (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB(s) from other insurance(s) are attached to the claim.</p>	<p>ONLY the 6-digit code should be entered for commercial and Medicare HMOs in this field.</p> <p>DO NOT enter dashes, hyphens, or the word TPL in the field.</p> <p>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE</p>
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.	

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Locator #	Description	Instructions	Alerts
21	ICD Ind. Diagnosis or Nature of Illness or Injury	<p>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.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).</p>
22	Resubmission Code	<p>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.</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>Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</p>

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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.	
24I	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 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.	
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 Date	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required. 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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Example of Billing for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

HEALTH INSURANCE CLAIM FORM

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

PICA										PICA					
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		TRICARE (ID#DOD#) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (ID#) <input type="checkbox"/>		FECA BLK LUNG (ID#) <input type="checkbox"/>		OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE										3. PATIENT'S BIRTH DATE MM DD YY 06 19 85		SEX M F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 1234567890123	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO		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 M F			
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE										c. AUTO ACCIDENT? YES NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES YES NO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Int 9 A. 78907 B. 78321 C. 78729 D. 53081 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. Prior Auth I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER					
12 15 14 12 15 14 24 45380 ABCD 900.00 1 NPI										25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gnt. claim, see back) YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 1234 \$ 900.00 \$ \$ 900.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)										32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH# (225) 555-4957 SURGI CENTER 123 MAIN ST ANY TOWN, LA 70000			
SIGNED IMA BILLER DATE 1/7/15										a. 1234567891 b. 1234567					

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



HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE #) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA (BLK LUNG) (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
LOU, JANNIE		1234567890123	
3. PATIENT'S BIRTH DATE MM DD YY M F SEX		5. INSURED'S ADDRESS (No., Street)	
06 19 85 M F X			
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S CITY STATE	
Self Spouse Child Other			
8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY M F SEX	
TPL Code if applicable		MM DD YY M F SEX	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
10. IS PATIENT'S CONDITION RELATED TO:		If yes, complete items 9, 9a and 9d.	
a. EMPLOYMENT? (Current or Previous) YES NO			
b. AUTO ACCIDENT? YES NO			
c. OTHER HEALTH PLAN? YES NO			
10a. RESERVED FOR LOCAL USE			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (For gmt. date, see back)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (For gmt. date, see back)	
SIGNED DATE		SIGNED DATE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD-10 Ind 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. R1084 B. R634 C. R1319 D. K219		23. PRIOR AUTHORIZATION NUMBER	
E. F. G. H. I. J. K. L.			
24. A. DATE(S) OF SERVICE 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. DAY'S OR UNITS H. ICD-10 QUAL I. RENDERING PROVIDER ID #			
1 10 08 15 10 08 15 24 45380 ABCD 900.00 1 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
		1234	
27. ACCEPT ASSIGNMENT? (For gmt. date, see back) YES NO		28. TOTAL CHARGE \$ 900.00	
		29. AMOUNT PAID \$	
30. BALANCE DUE \$ 900.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH# (225) 555-4957			
SIGNED IMA BILLER DATE 10/15/15		a. 1234567891 b. 1234567	

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

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/>											
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>		MEDICAID (Medicaid #) <input checked="" type="checkbox"/>		TRICARE (TRICARE #)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
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. INSURED'S ADDRESS (No., Street)		6. INSURED'S CITY (City, State, ZIP Code)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)		7. INSURED'S ADDRESS (No., Street)		8. INSURED'S CITY (City, State, ZIP Code)		9. INSURED'S POLICY GROUP OR FECA NUMBER		10. INSURED'S DATE OF BIRTH (MM DD YY)	
11. INSURED'S POLICY OR GROUP NUMBER		12. INSURED'S DATE OF BIRTH (MM DD YY)		13. INSURED'S SEX (M F)		14. INSURED'S OTHER CLAIM ID (Designated by NUCC)		15. INSURED'S INSURANCE PLAN NAME OR PROGRAM NAME		16. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		19. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		20. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	
23. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		24. OTHER DATE		25. QUAL		26. QUAL		27. QUAL		28. QUAL	
29. NAME OF REFERRING PROVIDER OR OTHER SOURCE		30. NAME OF REFERRING PROVIDER OR OTHER SOURCE		31. NAME OF REFERRING PROVIDER OR OTHER SOURCE		32. NAME OF REFERRING PROVIDER OR OTHER SOURCE		33. NAME OF REFERRING PROVIDER OR OTHER SOURCE		34. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
35. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		36. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		37. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		38. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		39. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		40. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
41. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))		42. ICD-9		43. ICD-9		44. ICD-9		45. ICD-9		46. ICD-9	
47. A. 78907		48. B. 78321		49. C. 78729		50. D. 53081		51. E. 53081		52. F. 53081	
53. I. 53081		54. J. 53081		55. K. 53081		56. L. 53081		57. M. 53081		58. N. 53081	
59. DATE(S) OF SERVICE		60. PLACE OF SERVICE		61. C. DATE OF SERVICE		62. PLACE OF SERVICE		63. D. DATE OF SERVICE		64. PLACE OF SERVICE	
65. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		66. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		67. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		68. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		69. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		70. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
71. F. 900.00		72. G. 1		73. H. NPI		74. I. NPI		75. J. NPI		76. K. NPI	
77. L. NPI		78. M. NPI		79. N. NPI		80. O. NPI		81. P. NPI		82. Q. NPI	
83. R. NPI		84. S. NPI		85. T. NPI		86. U. NPI		87. V. NPI		88. W. NPI	
89. X. NPI		90. Y. NPI		91. Z. NPI		92. AA. NPI		93. AB. NPI		94. AC. NPI	
95. AD. NPI		96. AE. NPI		97. AF. NPI		98. AG. NPI		99. AH. NPI		100. AI. NPI	
101. AJ. NPI		102. AK. NPI		103. AL. NPI		104. AM. NPI		105. AN. NPI		106. AO. NPI	
107. AP. NPI		108. AQ. NPI		109. AR. NPI		110. AS. NPI		111. AT. NPI		112. AU. NPI	
113. AV. NPI		114. AW. NPI		115. AX. NPI		116. AY. NPI		117. AZ. NPI		118. BA. NPI	
119. BB. NPI		120. BC. NPI		121. BD. NPI		122. BE. NPI		123. BF. NPI		124. BG. NPI	
125. BH. NPI		126. BI. NPI		127. BJ. NPI		128. BK. NPI		129. BL. NPI		130. BM. NPI	
131. BN. NPI		132. BO. NPI		133. BP. NPI		134. BQ. NPI		135. BR. NPI		136. BS. NPI	
137. BT. NPI		138. BU. NPI		139. BV. NPI		140. BW. NPI		141. BX. NPI		142. BY. NPI	
143. BZ. NPI		144. CA. NPI		145. CB. NPI		146. CC. NPI		147. CD. NPI		148. CE. NPI	
149. CF. NPI		150. CG. NPI		151. CH. NPI		152. CI. NPI		153. CJ. NPI		154. CK. NPI	
155. CL. NPI		156. CM. NPI		157. CN. NPI		158. CO. NPI		159. CP. NPI		160. CQ. NPI	
161. CR. NPI		162. CS. NPI		163. CT. NPI		164. CU. NPI		165. CV. NPI		166. CW. NPI	
167. CX. NPI		168. CY. NPI		169. CZ. NPI		170. DA. NPI		171. DB. NPI		172. DC. NPI	
173. DD. NPI		174. DE. NPI		175. DF. NPI		176. DG. NPI		177. DH. NPI		178. DI. NPI	
179. DJ. NPI		180. DK. NPI		181. DL. NPI		182. DM. NPI		183. DN. NPI		184. DO. NPI	
185. DP. NPI		186. DQ. NPI		187. DR. NPI		188. DS. NPI		189. DT. NPI		190. DU. NPI	
191. DV. NPI		192. DW. NPI		193. DX. NPI		194. DY. NPI		195. DZ. NPI		196. EA. NPI	
197. EB. NPI		198. EC. NPI		199. ED. NPI		200. EE. NPI		201. EF. NPI		202. EG. NPI	
203. EH. NPI		204. EI. NPI		205. EJ. NPI		206. EK. NPI		207. EL. NPI		208. EM. NPI	
209. EN. NPI		210. EO. NPI		211. EP. NPI		212. EQ. NPI		213. ER. NPI		214. ES. NPI	
215. ET. NPI		216. EU. NPI		217. EV. NPI		218. EW. NPI		219. EX. NPI		220. EY. NPI	
221. EZ. NPI		222. FA. NPI		223. FB. NPI		224. FC. NPI		225. FD. NPI		226. FE. NPI	
227. FF. NPI		228. FG. NPI		229. FH. NPI		230. FI. NPI		231. FJ. NPI		232. FK. NPI	
233. FL. NPI		234. FO. NPI		235. FP. NPI		236. FQ. NPI		237. FR. NPI		238. FS. NPI	
239. FT. NPI		240. FU. NPI		241. FV. NPI		242. FW. NPI		243. FX. NPI		244. FY. NPI	
245. FZ. NPI		246. GA. NPI		247. GB. NPI		248. GC. NPI		249. GD. NPI		250. GE. NPI	
251. GF. NPI		252. GH. NPI		253. GI. NPI		254. GJ. NPI		255. GK. NPI		256. GL. NPI	
257. GM. NPI		258. GN. NPI		259. GO. NPI		260. GP. NPI		261. GQ. NPI		262. GR. NPI	
263. GS. NPI		264. GT. NPI		265. GU. NPI		266. GV. NPI		267. GW. NPI		268. GX. NPI	
269. GY. NPI		270. GZ. NPI		271. HA. NPI		272. HB. NPI		273. HC. NPI		274. HD. NPI	
275. HE. NPI		276. HF. NPI		277. HG. NPI		278. HH. NPI		279. HI. NPI		280. HJ. NPI	
281. HK. NPI		282. HL. NPI		283. HM. NPI		284. HN. NPI		285. HO. NPI		286. HP. NPI	
287. HQ. NPI		288. HR. NPI		289. HS. NPI		290. HT. NPI		291. HU. NPI		292. HV. NPI	
293. HW. NPI		294. HX. NPI		295. HY. NPI		296. HZ. NPI		297. IA. NPI		298. IB. NPI	
299. IC. NPI		300. ID. NPI		301. IE. NPI		302. IF. NPI		303. IG. NPI		304. IH. NPI	
305. II. NPI		306. IJ. NPI		307. IK. NPI		308. IL. NPI		309. IM. NPI		310. IN. NPI	
311. IO. NPI		312. IP. NPI		313. IQ. NPI		314. IR. NPI		315. IS. NPI		316. IT. NPI	
317. IU. NPI		318. IV. NPI		319. IW. NPI		320. IX. NPI		321. IY. NPI		322. IZ. NPI	
323. JA. NPI		324. JB. NPI		325. JC. NPI		326. JD. NPI		327. JE. NPI		328. JF. NPI	
329. JG. NPI		330. JH. NPI		331. JI. NPI		332. JJ. NPI		333. JK. NPI		334. JL. NPI	
335. JM. NPI		336. JN. NPI		337. JO. NPI		338. JP. NPI		339. JQ. NPI		340. JR. NPI	
341. JS. NPI		342. JT. NPI		343. JU. NPI		344. JV. NPI		345. JW. NPI		346. JX. NPI	
347. JY. NPI		348. JZ. NPI		349. KA. NPI		350. KB. NPI		351. KC. NPI		352. KD. NPI	
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371. KW. NPI		372. KX. NPI		373. KY. NPI		374. KZ. NPI		375. LA. NPI		376. LB. NPI	
377. LC. NPI		378. LD. NPI		379. LE. NPI		380. LF. NPI		381. LG. NPI		382. LH. NPI	
383. LI. NPI		384. LJ. NPI		385. LK. NPI		386. LL. NPI		387. LM. NPI		388. LN. NPI	
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395. LU. NPI		396. LV. NPI		397. LW. NPI		398. LX. NPI		399. LY. NPI		400. LZ. NPI	
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407. MG. NPI		408. MH. NPI		409. MI. NPI		410. MJ. NPI		411. MK. NPI		412. ML. NPI	
413. MM. NPI		414. MN. NPI		415. MO. NPI		416. MP. NPI		417. MQ. NPI		418. MR. NPI	
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425. MY. NPI		426. MZ. NPI		427. NA. NPI		428. NB. NPI		429. NC. NPI		430. ND. NPI	
431. NE. NPI		432. NF. NPI		433. NG. NPI		434. NH. NPI		435. NI. NPI		436. NJ. NPI	
437. NK. NPI		438. NL. NPI		439. NM. NPI		440. NN. NPI		441. NO. NPI		442. NP. NPI	
443. NQ. NPI		444. NR. NPI		445. NS. NPI		446. NT. NPI		447. NU. NPI		448. NV. NPI	
449. NW. NPI		450. NX. NPI		451. NY. NPI		452. NZ. NPI		453. OA. NPI		454. OB. NPI	
455. OC. NPI		456. OD. NPI		457. OE. NPI		458. OF. NPI		459. OG. NPI		460. OH. NPI	
461. OI. NPI		462. OJ. NPI		463. OK. NPI		464. OL. NPI		465. OM. NPI		466. ON. NPI	
467. OO. NPI		468. OP. NPI		469. OQ. NPI		470. OR. NPI		471. OS. NPI		472. OT. NPI	
473. OU. NPI		474. OV. NPI		475. OW. NPI		476. OX. NPI		477. OY. NPI		478. OZ. NPI	
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485. PG. NPI		486. PH. NPI		487. PI. NPI		488. PJ. NPI		489. PK. NPI		490. PL. NPI	
491. PM. NPI		492. PN. NPI		493. PO. NPI		494. PP. NPI		495. PQ. NPI		496. PR. NPI	
497. PS. NPI		498. PT. NPI		499. PU. NPI		500. PV. NPI		501. PW. NPI		502. PX. NPI	
503. PY. NPI		504. PZ. NPI		505. QA. NPI		506. QB. NPI		507. QC. NPI		508. QD. NPI	
509. QE. NPI		510. QF. NPI		511. QG. NPI		512. QH. NPI		513. QI. NPI		514. QJ. NPI	
515. QK. NPI		516. QL. NPI		517. QM. NPI		518. QN. NPI		519. QO. NPI		520. QP. NPI	
521. QQ. NPI		522. QR. NPI		523. QS. NPI		524. QT. NPI		525. QU. NPI		526. QV. NPI	
527. QW. NPI		528. QX. NPI		529. QY. NPI		530. QZ. NPI		531. RA. NPI		532. RB. NPI	
533. RC. NPI		534. RD. NPI		535. RE. NPI		536. RF. NPI		537. RG. NPI		538. RH. NPI	
539. RI. NPI		540. RJ. NPI		541. RK. NPI		542. RL. NPI		543. RM. NPI		544. RN. NPI	
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551. RU. NPI		552. RV. NPI		553. RW. NPI		554. RX. NPI		555. RY. NPI		556. RZ. NPI	
557. SA. NPI		558. SB. NPI		559. SC. NPI		560. SD. NPI		561. SE. NPI		562. SF. NPI	
563. SG. NPI		564. SH. NPI		565. SI. NPI		566. SJ. NPI		567. SK. NPI		568. SL. NPI	
569. SM. NPI		570. SN. NPI		571. SO. NPI		572. SP. NPI		573. SQ. NPI		574. SR. NPI	
575. SS. NPI		576. ST. NPI		577. SU. NPI		578. SV. NPI		579. SW. NPI		580. SX. NPI	
581. SY. NPI		582. SZ. NPI		583. TA. NPI		584. TB. NPI		585. TC. NPI		586. TD. NPI	
587. TE. NPI		588. TF. NPI		589. TG. NPI		590. TH. NPI		591. TI. NPI		592. TJ. NPI	
593. TK. NPI		594. TL. NPI		595. TM. NPI		596. TN. NPI		597. TO. NPI		598. TP. NPI	
599. TQ. NPI		600. TR. NPI		601. TS. NPI		602. TT. NPI		603. TU. NPI		604. TV. NPI	
605. TW. NPI		606. TX. NPI		607. TY. NPI		608. TZ. NPI		609. UA. NPI		610. UB. NPI	
611. UC. NPI		612. UD. NPI		613. UE. NPI		614. UF. NPI		615. UG. NPI		616. UH. NPI	
617. UI. NPI		618. UJ. NPI		619. UK. NPI		620. UL. NPI		621. UM. NPI		622. UN. NPI	
623. UO. NPI		624. UP. NPI		625. UQ. NPI		626. UR. NPI		627. US. NPI		628. UT. NPI	
629. UU. NPI		630. UV. NPI		631. UW. NPI		632. UX. NPI		633. UY. NPI		634. UZ. NPI	
635. VA. NPI		636. VB. NPI		637. VC. NPI		638. VD. NPI		639. VE. NPI		640. VF. NPI	
641. VG. NPI		642. VH. NPI		643. VI. NPI		644. VJ. NPI		645. VK. NPI		646. VL. NPI	
647. VM. NPI		648. VN. NPI		649. VO. NPI		650. VP. NPI		651. VQ. NPI		652. VR. NPI	
653. VS. NPI		654. VT. NPI		655. VU. NPI		656. VV. NPI		657. VW. NPI		658. VX. NPI	
659. VY. NPI		660. VZ. NPI		661. WA. NPI		662. WB. NPI		663. WC. NPI		664. WD. NPI	
665. WE. NPI		666. WF. NPI		667. WG. NPI		668. WH. NPI		669. WI. NPI		670. WJ. NPI	
671. WK. NPI		672. WL. NPI		673. WM. NPI		674. WN. NPI		675. WO. NPI		676. WP. NPI	
677. WQ. NPI		678. WR. NPI		679. WS. NPI		680. WT. NPI		681. WU. NPI		682. WV. NPI	
683. WX. NPI		684. WY. NPI		685. WZ. NPI		686. XA. NPI		687. XB. NPI		688. XC. NPI	
689. XD. NPI											

CHAPTER 29: AMBULATORY SURGICAL CENTERS

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)



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE #) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA (FECA #) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE		3. PATIENT'S BIRTH DATE MM DD YY 06 19 85 SEX F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)		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 TPL Code if applicable 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) YES NO b. AUTO ACCIDENT? YES NO c. OTHER (Specify) YES NO 10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I, the undersigned, hereby certify that the information furnished is true and correct to the best of my knowledge and belief. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. R 1084 B. R 634 C. R 13 19 D. K2 19 E. F. G. H. I. J. K. L.		22. RE-SUBMISSION CODE A02 ORIGINAL REF. NO. 5303134567800	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER	
1 10 08 15 10 08 15 24 45380 ABCD 900.00 1 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 1234		26. PATIENT'S ACCOUNT NO. 1234	
27. ACCEPT ASSIGNMENT? (For gmt. date, see back) YES NO		28. TOTAL CHARGE \$ 900.00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 900.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED IMA BILLER DATE 10/15/15		32. SERVICE FACILITY LOCATION INFORMATION a. b. 33. BILLING PROVIDER INFO & PH# (225) 555-4957 SURGI CENTER 123 MAIN ST ANY TOWN, LA 70000 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

APPENDIX B: CLAIMS FILING

PAGE(S) 12

Example of Blank Form



HEALTH INSURANCE CLAIM FORM

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

PICA ☐ ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA SICKLING ☐ OTHER ☐
(Medicare#) (Medicaid#) (IDMDo#) (Member ID#) (ID#) (ID#)

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
b. AUTO ACCIDENT? YES ☐ NO ☐ PLADE (State)
c. OTHER ACCIDENT? YES ☐ NO ☐

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

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.

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 EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. FIRST Party I. ID. QUAL J. RENDERING PROVIDER ID. #

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Raved for NUCC Use ☐

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE

PLEASE PRINT OR TYPE

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