#### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

APPENDIX B: CLAIMS FILING PAGE(S) 13

#### **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.

**ISSUED:** 12/09/24 08/10/22 **REPLACED:** 

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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 Identification (ID) Number	Required – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibility Verification System (MEVS), eMEVS or Recipient Eligibility Verification System (REVS).  NOTE: The beneficiaries' 13-digit Medicaid ID number must be used to bill claims. The card control number (CCN) 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 (MI).	
3	Patient's Date of Birth (DOB)	Situational – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example, 01 02 07).	
	Sex	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	<b>Optional</b> – 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.	

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Locator #	Description	Instructions	Alerts
8	RESERVED FOR NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE		
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 third-party liability (TPL) carrier code is <b>required</b> in this block. The carrier code is indicated on the MEVS) response as the Network Provider Identification Number.  Make sure the explanation of benefits (EOBs) from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered for commercial and Medicare Health Maintenance Organizations (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 Federal Employees Compensation Act (FECA) Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's DOB Sex	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
11b	Employer's Name or School Name	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	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	National Provider Identifier (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	International Classification of Diseases (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).

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### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

Locator #	Description	Instructions	Alerts
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 = TPL 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.
23	Prior Authorization (PA) 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.  e(s) of Service  Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (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).	

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### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

Locator #	Description	Instructions	Alerts
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	<b>Required</b> Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> Enter the number of units billed for the procedure code entered on the same line in 24D	
24Н	Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
<b>24</b> I	ID Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID #	Leave Blank	
25	Federal Tax ID Number	Optional.	
26	Patient's Account Number	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?	<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.	
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	Reserved for NUCC use	Leave Blank.	

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Locator #	Description	Instructions	Alerts
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	Unlabeled	<b>Situational</b> – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required - Enter the billing provider's 10 digit NPI number.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit Medicaid Provider Number must appear on paper
		<b>ID Qualifier - Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	claims.

### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

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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 T
MEDICARE MEDICAID TRICARE CHAMPVA	GROUP FECA OTHER HEALTH PLAN BLKLUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member II	D#) (ID#) (ID#) (ID#)	1234567890123
PATIENT'S NAME (Last Name, First Name, Middle Initial)     LOU, JANNIE	3. PATIENTS BITTH DATE SEX MM DD YY 06 19 85 M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
CITY	8. RESERVED FOR NUCC USE	CITY
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
8.0 THEK INSUREDS INVINE (cast Name, Flist Name, Middle linear)	TO IS PATIENT S CONDITION RELATED TO.	III. INSUREDS POLICI GROUP ON PECK NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
TPL Code if applicable b. RESERVED FOR NUCCUSE	YES NO b. AUTO ACCIDENT? PLACE (State)	M F b. OTHER CLAIM ID (Designated by NUCC)
	CARADIE	
c. RESERVED FOR NUCC USE	a COLUMN I LL	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
FXΔ	MPI F OF	// IS // // // // // // // // // // // // //
TEAD BACK OF FORM BEFORE SMITH LETING  12. PATIENTS OR AUTHORIZED PERSONS SIGNATURE I authorize the to process this claim. I also request payment of government benefits either to	a Sicritical mils Forcial release of any medical or other information necessary or myself or to the party who accepts assignment	<ol> <li>NooRes S OR As HORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
below. SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0	THER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM   DD   YY MM   DD   YY
QUAL QUI		FROM TO
174	NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO TO TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	rvice line below (24E) ICD led Q	YES NO
	rvice line below (24E)   ICD Ind.  9   78729   D.  53081	22. RESUBMISSION ORIGINAL REF. NO.
E. F. G.	н	23. PRIOR AUTHORIZATION NUMBER
I	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
	lain Unusual Circumstances) DIAGNOSIS	F. G, H. L. DAYS B'EST ID. RENDERING Family SCHARGES UNITS   Find QUAL. PROVIDER ID. #
1 12 15 14 12 15 14 24 4538	D ABCD	900 00   1   NPI
2		NPI NPI
3		
<u> </u>		NPI
4		NPI NPI
5		
		NPI NPI
6		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	(For govt. daims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FA	YES NO CILITY LOCATION INFORMATION	s 900 00 s s 900 00 33. BILLING PROVIDER INFO & PH# (225 ) 555-4957
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		SURGI CENTER
apply to this bill and are made a part thereof.)		123 MAIN ST
SIGNED IMA BILLER DATE 1/7/15 a.	b.	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

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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  APPROVADE BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12    PICA   PICA	
PPCOVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12   PICA	
MEDICARE   MEDICARD   TRICARE   CHAMPVA   GROUP   HEALTH PLAN   BLK LUNG   (109)   (	
Medicare 8  X (Medicaid 8  (IDMDoD8)	em 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	
DOLD	
Self Spouse Child Other  ITY STATE 8. RESERVED FOR NUCC USE  PCODE TELEPHONE (indude Area Code) ( ) OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DOUTE OF, BIRTH SEX	
TY STATE 8. RESERVED FOR NUCC USE  CITY  ZIP CODE  TELEPHONE (Include Area Code) ( )  OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  10. IS PATIENT'S CONDITION RELATED TO:  11. INSURED'S POLICY GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BIRTH  SEX	
P CODE TELEPHONE (Indude Area Code)  ( )  OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BRTH  SEX	
( ) 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  OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BITTH  SEX	E
OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BIRTH  SEX	
OTHER INSURED'S POLICY OR GROUP NUMBER  a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BITTH SEX	
MM + DD + YY	
MM + DD + YY	
RESERVED FOR NUCCUSE  b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)	
C A BS A DA . E.	
RESERVED FOR NUCC USE C. OT ARCHAN LAN C. INSURANCE PLAN NAME OR PROGRAM NAME	
YES NO	
NSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
EVANDIE OF ICE 1ND //yes, complete items 9, 9e and 9d.	
READ BACK OF FORM 1 FOR 1 W 1 C is 14th FOIr 1.  PATIENTS OR AUTHORIZED PERSONS SIGN. A LOCATE A results on any many that the disconcess by spirit of mesons to write to the undersigned physician or supplied on the secretary of power ment benefits either to myself or to the party who accepts assignment secretary to write to the undersigned physician or supplied on the secretary of the party who accepts assignment secretary to write the secretary of the secretary	ize lier for
SIGNED DATE SIGNED	
DATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LMP) 15.0THER DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD YY MM DD YY M DD YY M DD YY M DD YY MM DD YY M DD	ON
QUAL QUAL FROM TO	
NAME OF RÉFERRING PROVIDER OR OTHER SOURCE 17a. 18. HOSPITALIZATION DATES RELATED TO CURRENT DE TO C	ş
71b. NPI FROM TO	
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  20. OUTSIDE LAB?  \$ CHARGES  YES NO	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 22. RESUBMISSION CODE ORIGINAL REF. NO.	
R 1084 B R 634 C R 1319 D K 219	
F. G. H. 23. PRIOR AUTHORIZATION NUMBER	
K L L	
A. DATE(S) OF SERVICE B. C. D. PROCEQUIESS, SERVICES, OR SUPPLIES E. F. G. H. I. J. T. FROM TO BY MM DD YY SERVICE EMG C. PHYCHOCKS MODIFIER DIAGNOSS POINTER \$ CHARGES UNITS 10.10. RENDERN QUAL. PROVIDER I	(G ID.#
0 08 15 10 08 15 24 45380   ABCD 900 00 1 NP	
NPI NPI	
NPI	
NPI	
FEDERAL TAX.LD. NUMBER SSN EIN 26. PATIENTS ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE (For good, datum, see back)	DUE
(For govt. claims, see back)	00 00
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS  32. SERVICE FACILITY LOCATION INFORMATION  33. BILLING PROVIDER INFO & PH# (225) 555-4957	- /1-0
INCLUDING DEGREES OR CREDENTIALS (contry that the statements on the reverse apply to this bit and are made a part thereof.)  SURGI CENTER 123 MAIN ST ANY TOWN, LA 70000	
ONED IMA BILLER DATE 10/15/15 a. b. 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)

PICA	NUCC) 02/12			
MEDICARE MEDICAID TRICARE	CHAMPVA GROUP	FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare#) X (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#)	N BLKLUNG (ID#) (ID#)	1234567890123	( or roganin man r)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTI		4. INSURED'S NAME (Last Name)	ne, First Name, Middle Initial)
OU, JANNIE PATIENT'S ADDRESS (No., Street)	06   19   6. PATIENT RELAT	85 M F X IONSHIP 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	a Code)		ZIP CODE	TELEPHONE (Include Area Code)
( )				( )
OTHER INSURED'S NAME (Last Name, First Name, Middl	le Initial) 10. IS PATIENT'S C	CONDITION RELATED TO:	11. INSURED'S POLICY GROU	P OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT?	(Current or Previous)	a. INSURED'S DATE OF BIR'S	TH SEX
PL Code if applicable RESERVED FOR NUCCUSE	h AUTO ACCIDENT		b. OTHER CLAIM ID (Designate	M F
	b. AUTO ACCIDEN	PLACE (State)	S. STER GENERAL (Designate	n oj
RESERVED FOR NUCC USE	a. The Act of	VIFLE	c. INSURANCE PLAN NAME OF	R PROGRAM NAME
NSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FO	ES NO OR LOCAL USE	d ISTHERE ANOTHER HEALT	TH BENEFIT PLAN?
F	$X\Delta MD$	I F OF		Tyes, complete items 9, 9e and 9d.
READ BACK OF FORM BEF	OM: LETING & SIGNING THIS FO	all or other information necessary		ED PERSON'S SIGNATURE I authorize to the undersigned physician or supplier for
to process this claim. I also request payment of government below.	benefits either to myself or to the part	y who a coepts assignment	services described below.	
SIGNED	DATE		SIGNED	
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY	Y (LMP) 15.OTHER DATE QUAL.	MM DD YY	16. DATES PATIENT UNABLE T	TO WORK IN CURRENT OCCUPATION TO MM   DD   YY
QUAL NAME OF REFERRING PROVIDER OR OTHER SOURCE		i	j	RELATED TO CURRENT SERVICES
	71b. NPI		FROM	то
ADDITIONAL CLAIM INFORMATION (Designated by NU	)C)		20. OUTSIDE LAB? YES NO	\$ CHARGES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R	telate A-L to service line below (24E)	IOD IIII. O	22. RESUBMISSION CODE	ORIGINAL REF. NO.
78907 B. 78321	c. 78729	D [53081	A 02 23. PRIOR AUTHORIZATION N	4361134567800
F	G K.	H [	20. PRIOR ADTIONEATION	CHIOLIY
A. DATE(S) OF SERVICE B. C. From To PLACEOF M DD YY MM DD YY SERVICE EMG	D.PROCEDURES, SERVICES, (Explain Unusual Circums	tances) DIAGNOSIS	F. G. DAYS OR UNITS	H. I. J. BPSDT ID. RENDERING
M DD YY MM DD YY SERMOE EMG	CPT/HCPCS MO	DIFIER POINTER	\$ CHARGES OR UNITS	Plan QUAL. PROVIDER ID.#
2 15 14 12 15 14 24	45380	ABCD	900 00 1	NPI
10 14 12 10 14 24				
				NPI
				NPI
				NPI NPI
				NPI NPI
				NPI
				NPI NPI
FEDERAL TAXLD NUMBER SSN EN 20	B. PATIENTS ACCOUNT NO.	27. ACCEPT ASSIGNMENT? For good, dafine, see back)		NPI NPI NPI NPI 0 AMOUNT PAID
FEDERAL TAX LD. NUMBER SSN EIN 21	234	YES NO	s 900 00	NPI
FEDERAL TAX LD. NUMBER SSN EIN 21		YES NO		NPI

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

EALTH INSURANCE CL				
PROVED BY NATIONAL UNIFORM CLAI PICA	IM COMMITTEE (NUCC) 02/12			PICA T
MEDICARE MEDICAID TR	RICARE CHAMPVA	GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For	Program in Item 1)
	D#/DoD#) (Member ID#)	) //Dill) //Dill) (/Dill)	1234567890123	
PATIENT'S NAME (Last Name, First Nam	me, Middle Initial)	PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle II	nitial)
OU, JANNIE PATIENT'S ADDRESS (No., Street)	6	06 19 85 M F X	7. INSURED'S ADDRESS (No., Street)	
, , , , , , , , , , , , , , , , , , , ,		Self Spouse Child Other	,	
TY	STATE 8.	RESERVED FOR NUCC USE	СІТУ	STATE
P CODE TELEPHO	IONE (Indude Area Code)		ZIP CODE TELEPHONE (Includ-	e Ama Code)
(	)		( )	371104 0040)
OTHER INSURED'S NAME (Last Name,	, First Name, Middle Initial) 1	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
OTHER INSURED'S POLICY OR GROU	JP NUMBER a.	. EMPLOYMENT? (Current or Previous)	MM   DD   YY	SEX
L Code if applicable ESERVED FOR NUCCUSE		YES NO  AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	F
	0	CARADA F	and the same of the same	
ESERVED FOR NUCC USE	C.	<b>DAINILLE</b>	c. INSURANCE PLAN NAME OR PROGRAM NAME	
		YES NO		
NSURANCE PLAN NAME OR PROGRA	AM NAME	0d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
READ BACK OF	FORM E FFOR A DM CO IN IA	AG IN 2 IHIS FOR A	3. IN: JRF /S OR AUT TO ZED PERSON'S SIGNAT	
PATIENT'S OR AUTHORIZED PERSON to process this claim. I also request payme	N'S SIGN	was of any mountain their in the of in necessary myself or to the party who accepts assignment	playment of more an boundits to the undersigned physiservices described below.	sician or supplier for
below.				
SIGNED	V ~ DDECNIANOV/LND. THE OTH	DATE HER DATE	SIGNED	T OCCUPATION
DATE OF CURRENT ILLNESS, INJURY	QUAL.	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT MM   DD   YY TO   TO	DD YY
NAME OF REFERRING PROVIDER OR			18. HOSPITALIZATION DATES RELATED TO CURREN	л <sub>.SERVICES</sub>
	71b. N	IPI .	FROM TO	
ADDITIONAL CLAIM INFORMATION (D	Designated by NUCC)	•	20. OUTSIDE LAB? \$ CHARGES	I
DIAGNOSIS OR NATURE OF ILLNESS	OR INJURY Relate A-L to service	ce line below (24E) ICD Ind. 0	YES NO  22. RESUBMISSION ORIGINAL REF. NO.	
R 1084 B.   R6			A02 ORIGINAL REF. NO. 530313456780	0
F	G.	н	23. PRIOR AUTHORIZATION NUMBER	
J	K.L.	L.		
DATE(S) OF SERVICE     From To     DD YY MM DD YY	PLACEOF (Explain	URES, SERVICES, OR SUPPLIES E. In Unusual Circumstances) DIAGNOSIS MODIFIER POINTER	F. G. H. I. DAYS BYSOT ID. OR Family S CHARGES UNITS Plun QUAL.	J. RENDERING PROVIDER ID. #
TO TO MM DO TY	GENERAL ENG   CFT/HCFCS	MOUFIER POINTER	WITH THE COME.	PROVIDER ID. #
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<u> </u>			i NFI	
	T		NPI	
PEDERAL TAX I.D. NUMBER 8	SSN EIN 26. PATIENT'S ACC	COUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. daims, see back)		30. BALANCE DUE
CONTRACT OF STREET	1234	YES NO	s 900 00 s	\$ 900 00
SIGNATURE OF PHYSICIAN OR SUPP INCLUDING DEGREES OR CREDENTI	IALS	ILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (225)5	55-4957
(I cartify that the statements on the rever apply to this bill and are made a part the			SURGI CENTER 123 MAIN ST	
			ANY TOWN, LA 70000	
GNED IMA BILLER DATE	E 10/15/15 a.	b.	a. 1234567891 b. 12345	67
ICC Instruction Manual available	ele at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM	CMS-1500 (02-1

### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

APPENDIX B: CLAIMS FILING PAGE(S) 13

### **Example of Blank Form**

回信回 ではない 回父者 HEALTH INSURANCE CLAIM FORM		
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/1	2	
PICA		PICA TO
1. MEDICARE MEDICAID TRICARE CHAMI (Medicare#) (Medicald#) (IDM/DoD#) (Membi	- HEALTH PLAN - BLK LUNG -	1 a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Lest Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
	MM DO YY	930 14000
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED  Belf Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY	8. RESERVED FOR NUCC USE	CITY
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (include Area Code)
9, OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)  YES NO	ZIP CODE  TELEPHONE (Include Avea Code)  ( )  11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM DD W M F  b. OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OR PROGRAM NAME  d. IS THERE ANOTHER HEALTH BENEFIT PLANT
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENTY PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
a. RESERVED FOR NUCC USE	G. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO # yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLET 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I suthorize to to process this claim. I also request payment of government benefits sittle below.	VG & SIGNING THIS POPAL.  or release of any medical or other information necessary or to myself or to the party who accepts assignment.	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED	DATE	SIGNED
	OTHER DATE MAN DD YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DO YY TO TO THE TOWN TO TO THE TOWN TOWN TO THE TOWN TO THE TOWN TO THE TOWN TO THE TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN
and the second s	79.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	76. NPI	FROM TO 20. OUTSIDE LAB? \$ CHARGES
10. Activities of the control of the		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	rvice line below (24E) ICD Ind.	22. RESUBMISSION ORIGINAL REF. NO.
A B. C.	D	
E. F. G.	Н.	2S. PRIOR AUTHORIZATION NUMBER
1. J. K. 24. A. DATE(S) OF SERVICE B. C. D. PRO	EDURES, SERVICES, OR SUPPLIES E.	F9_ H. l. J.
	olain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. I. PART PROFILE ID. RENDERING PART QUAL PROVIDER ID. 9
		S CHARGES UNTS PROPERTY OLD PROVIDER ID. •  NPI  NPI  NPI  NPI
		NPI
		NPI NPI
		NPI NPI
		NPI NPI
25. FEDERAL TAX LD. NUMBER 88N EIN 26. PATIENT	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Ravd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (1 certify that the statement on the reverse apply to this bill and are made a part thereof.)	YES NO NO NO NOTICE NOT	\$ S. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE 8.	DI EACE DRINT OR TVDE	a. b.